MAY, 1954

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

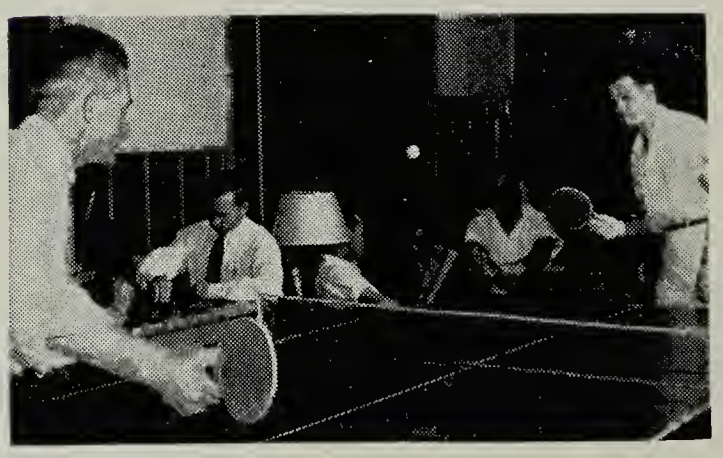
N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of white male and female problem drinkers. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $72 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, a social worker, a recreation director, an occupational therapist, and four attendants.



The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.
2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history compiled by the patient's family physician are necessary.
3. A fee of $72, in cash or certified check, must be paid upon admission.
4. The signing, on admission, of a letter-statement, which requests voluntary admission.

Admitting Hours

8 A.M. to 3 P.M. Monday through Friday
8 A.M. to 11 A.M. Saturday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM
OF THE
NORTH CAROLINA HOSPITALS BOARD OF CONTROL

S. K. PROCTOR
Executive Director

NORBERT L. KELLY, Ph.D.
Educational Director

LORANT FORIZS, M.D.
Clinical Director

INVENTORY

VOLUME IV — NUMBER 1

MAY, 1954

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices, 429 Agriculture Building, P. O. Box 9118, Raleigh, North Carolina.

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This journal is printed as a public information service, currently serving 15,500 readers. Persons desiring a place on the free mailing list must send in a written request. This journal will not be sent to persons other than those requesting it.

Write: INVENTORY, Box 9118, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

Alcohol Education

We have just completed a unit on Alcoholism and Habit Forming Drugs and we feel that the wonderful supply of literature that you sent us played a great part in making it one of the most interesting and most helpful units of work that we have done this year . . .

Until this year, I have been undecided as to whether or not eighth grade was the proper place for this study, as we have done it, but I am now convinced that this is the very age to begin, as they are doing a great deal of thinking about the things that they see boys and girls do in high school. Through all of the information that they have gained I think they can make better decisions.

Miss Selma Johnson
Alexander Graham
Junior High School
Fayetteville, N. C.

Pennsylvania Program Expands

It is my hope to come to North Carolina and discuss (organization and operation of NCARP) with you personally and see the facility at Butner under Dr. Forizs' direction, because I am sure this will aid me greatly in my assumption of leadership in this work here in Pennsylvania. Your program is so highly recommended by former patients, as well as receiving renown throughout the eastern area of the United States.

Earl F. Hoerner, M.D., Director
Division of Alcoholic Studies
and Rehabilitation,
State of Pennsylvania

Inventory Gets Around

I recently had the good fortune of being able to peruse several copies of your journal, INVENTORY, and was delighted by its excellent format and material. The work which is being done at Butner is an inspiration to all of those who are engaged in the fight against alcoholism . . . My group would be under a great obligation to your organization if the latter could see its way clear to put us on your free mailing list for INVENTORY.

Secretary, Subiaco AA Group
Subiaco, Western Australia

Films On Alcoholism

I assure you that the public in general is benefiting greatly from these (films on alcoholism furnished State Board of Health by NCARP) and other films you have made available for distribution. I would like to send over to you at a later date a folder of letters expressing appreciation for this film service.

Roger G. Whitley, Supervisor
Film Records & Equipment
N. C. State Board of Health

The showing of films on alcoholism and personality development is playing a significant and very important role in the education of the general public toward an understanding of alcoholism and toward helping parents to guide their children's emotional growth to maturity—the best insurance against alcoholism.

W.S.C.S. Talk By Kelly

Your contribution to our study at the Duke Memorial Methodist Church cannot be measured in mere words. The ladies were very much impressed with your subject matter and your manner of delivery . . .

Kathleen B. Edens
Durham, N. C.

Program Pointers

By S. K. Proctor

EXECUTIVE DIRECTOR

BECAUSE of the large number of well-qualified applicants for the scholarships offered by this Program to the Yale Summer School of Alcohol Studies this year the scholarship committee had a hard time deciding on the scholarship holders. Qualified applicants came from many professional and semi-professional classifications that need to be represented at the Summer Studies. The final selections had to be based on as wide a representation as possible, and for that reason we were unable to award scholarships to many of the qualified applicants. We hope that these fine people are not discouraged, however, and that they will re-apply next year.

Summer Studies

The plans are now complete for our own Summer Studies on Facts About Alcohol at three North Carolina colleges this summer. Advance registrations and inquiries indicate that this expanded educational program for teachers and prospective teachers is an appreciated and needed teacher aid. As you may know, these study courses provide three quarter hours' college credit each and will be held in cooperation with East Carolina College at Greenville, Appalachian State Teachers College at Boone, and A. & T. College at Greensboro. I suggest that persons interested in the study course, which is identical at all three colleges, contact the Registrar of the college they desire to attend at the earliest possible moment.

Miss Roberta Lytle, Psychiatric Social Work Supervisor now attached to this office, and I recently visited each of the Mental Hygiene Clinics in the State and discussed ways and means of more closely coordinating the work of the NCARP and the Clinics and improving services to alcoholic patients and their families. Tentative plans for a joint meeting of professional workers of the Clinics and this Program have been made to further this objective.

Important Aid

The Clinics are, and have been, making their services available to all ex-Butner patients and their families who will accept this continuing service. The importance of this aid to continued sobriety should not be underestimated. Too often, ex-Butner patients feel that the treatment at Butner ARC is complete, and that it should enable them to remain sober henceforth and forevermore without further help from local agencies. Although some ex-patients seem to recover without consciously seeking further treatment, the majority who recover accept continuing aid from Mental Hygiene Clinics, Alcoholics Anonymous, and/or their pastors.

Continued high public interest in learning about the nature of alcoholism and what local communities can do about the problem is being reflected by the large numbers of requests on our speakers' bureau. Dr. Kelly and I recently checked our calendars and discovered that we have made nearly 100 talks before public gatherings since last September, mostly at night. If each person who listened to these talks left with the feeling that he had a slightly better understanding of the problem we consider the extra demand on our time well worth the effort.

INVENTORY
THIS ISSUE

As a child psychiatrist, Dr. Joseph Carpentieri, Director of the Raleigh and Wake County Mental Hygiene Clinic, feels that early recognition and treatment of childhood emotional disturbances is essential for the prevention of adult personality illnesses, including alcoholism. In this issue, Dr. Carpentieri spells out for **Inventory** readers some of the common symptoms and causes of personality problems in children, explaining that they may be successfully treated. Recognizing that most parents are skittish about admitting that their child might have an emotional problem, the psychiatrist makes a plea for a realistic view of the problem.

Carpentieri

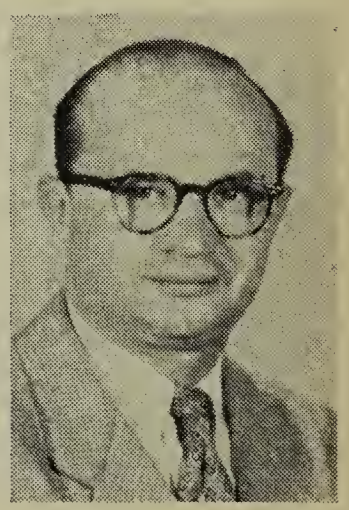
Dr. Lorant Forizs admits that there is much we do not know about the human personality. However, during Forizs' tenure as Clinical Director of the Butner ARC, he has learned a great deal about the personalities of alcoholics. Research has shown that problem drinkers use alcohol to relieve their uncomfortable feelings. Forizs' explanation of how these feelings arise and become a part of the alcoholic's personality adds greatly to our knowledge and understanding of the illness. We are printing Dr. Forizs' **Personality Factors In Alcoholism** by permission of the **N. C. Medical Journal.**

Forizs

Wives of alcoholics have traditionally been thought of as helpless victims of circumstance. Tain't necessarily so, says **Thelma Whalen,** in her article, **Wives of Alcoholics,** which we are reprinting with her permission and that of the Yale Quarterly Journal. Miss Whalen writes from a long experience in family casework, having been executive of the Family Service Agency of Dallas, Texas, since 1936. Looking at some of the women who come to a family service agency for help with the problems of being married to an alcoholic, she finds that some of these wives have traits within their own personalities which seem to contribute to their alcoholic husband's drinking problem. Miss Whalen's classifications of alcoholics' wives are accented by cartoons from the Editor's pen.

Whalen

Toward Understanding Alcoholics is the contribution of a Californian, **Dr. Arthur Lerner** of Los Angeles. Dr. Lerner is a psychologist with the unique position of Counselor at the Los Angeles City Jail. This program is a joint undertaking of the Adult Education Branch of the Los Angeles City Schools and the Bureau of Corrections of the local police Department, and appears to be one of the first of its kind in the country. Like other jails, the Los Angeles jail collects a large number of alcoholic prisoners and Dr. Lerner's article comes out of his experience in counseling with them.



Lerner

EYE OPENERS

Capsule information

and comment

Everyone likes to be helpful. Some people who try to help alcoholics, however, don't seem to get anywhere. They mean well but they just don't know enough about the illness of alcoholism to be really helpful. Here are some suggestions for effectively helping alcoholics: (1) Never shield or cover up anyone with a drinking problem. Do something constructive about it promptly. (2) Consult an understanding physician. (3) Let the alcoholic know that you realize he is suffering from an illness over which he has no control. (4) Don't give him tirades and preach to him. This may relieve your feelings but they won't help him. (5) Encourage the person to read some reliable literature on alcoholism. (6) Let him know that help is available when he desires it. (7) The alcoholic feels that he is alone against the world, that everyone looks down on him for his inebriety. Prove to him that he is wrong by being his friend. (8) After these things have been done, it is necessary to let him take the natural consequences of his drinking without too much protection from you. Be patient. When he is ready for help he will call for it.

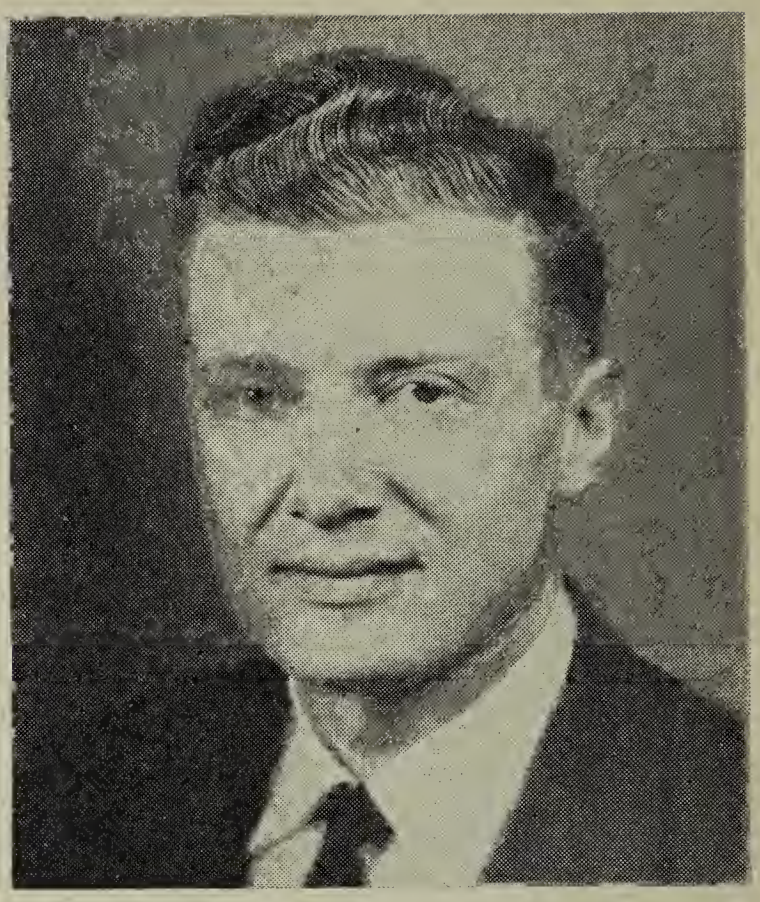
The Canadian Office of Health and Welfare published figures recently which show that the United States leads the other countries of the world in the number of alcoholics per 100,000 population 20 years of age and over. France is our nearest competitor, followed by Sweden, Switzerland, Denmark, Canada, Norway, Finland, and Italy in that order.

Alcoholism is a symptom of retarded emotional growth. Emotionally the alcoholic has never developed adult maturity. This unhappy condition causes a distorted perspective of life problems, as well as a distorted, inadequate reaction to them. This does not mean that alcoholics are intellectually inferior to non-alcoholics. It simply means that the blocks to emotional growth need to be removed. Dr. George H. Preston in his book, *The Substance of Mental Health* defines emotional maturity as consisting of the ability to live: (1) Within the limits imposed by the bodily equipment. (2) With other human beings. (3) Happily. (4) Productively. (5) Without being a nuisance.

Recovery or rehabilitation, rather than cure, is always referred to in the treatment of alcoholism, for there is no cure —at least to date. A cure would mean that the uncontrolled drinker could resume moderate drinking after treatment. The alcoholic must accept the fact that he can never return to social or moderate drinking without probable disastrous results. Once an alcoholic always an alcoholic, just as the diabetic always remains a diabetic. Both can and do recover, but recovery is conditional. Neither can forget the rules of health which must be followed to maintain that recovery.

Frequent "blackouts" are one of the early warning signals of alcoholism. Researchers tell us that the overwhelming majority of alcoholics report repeated blackouts fairly early in their drinking careers. Alcoholics don't have a monopoly on "blackouts." A moderate drinker may experience a "blackout," but an alcoholic will have them frequently as his drinking gets more and more out of control. This "blackout" reaction to drinking doesn't imply "passing out" as some people believe. It is, rather, a lack of memory for events at the time of intoxication. The "blackout" subject will experience a painful bewilderment when he tries to remember his drunken behavior.

Personality Sketches



JOHN A. EWING, M. D.

Senior Physician
Butner State Hospital

OUR INVENTORY personality - of - the - month might be the subject of a riddle which goes something like this: How can a Scotsman live 15 miles from Durham, move all the way across the Atlantic ocean and still live 15 miles from Durham? Dr. John Ewing attests to the fact that it can be done, simply by moving from a spot 15 miles from Durham, *England* and taking up his residence in Butner, also 15 miles from Durham—North Carolina. A coincidence, perhaps, but certainly a happy one for the N. C. Alcoholic Rehabilitation Center and the Butner State Hospital.

Dr. Ewing is the Senior Physician on the staff of the 1600-bed Butner State Hospital and psychiatrist on the staff of the Alcoholic Rehabilitation Center. As Senior Physician with the hospital he supervises the care and treatment of the 800 to 900 mental patients in the female section. A large portion of his working hours is spent conducting group and individual psychotherapy with his mental patients and also with the alcoholic patients at the Center. In addition, he holds a part-time Clinical Instructorship in Psychiatry at N. C. Memorial Hospital, is constantly carrying on important research into the personality factors in alcoholism, writes articles based on his research, and fills many lecture engagements at meetings and institutes all over the State.

The pleasantly rolling "burr" in his voice attests to Dr. Ewing's pure Scottish lineage. Having spent his teens near Edinburgh, he took his undergraduate study and medical school training at the University of Edinburgh. Here Ewing's interest in psychiatry was kindled by the famous Professor D. K. Henderson whose boundless enthusiasm for psychiatry's mission in all areas of life was caught by his young student. A year of work in the mental hospital in Edinburgh cemented Ewing's decision to specialize in psychiatry, He then moved to England where he combined duties as psychiatric assistant in several out-patient clinics with additional special training at the University of Durham. Three and a half years of work and study were rewarded with the degree of Doctor of Psychological Medicine from the University of London.

It was while he was at Durham that Ewing had his first professional contacts with alcoholics. He found them "fascinating people" to work with, but

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ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

IS YOUR CHILD *Emotionally Disturbed?*

Early attention by parents to signs of emotional problems in their children may prevent their developing alcoholism or other personality illnesses when they grow up.

BY JOSEPH CARPENTIERI, M.D.

DIRECTOR, MENTAL HYGIENE CLINIC
OF RALEIGH AND WAKE COUNTY

THE emotionally disturbed child is basically an anxious child who in general is uncomfortable and suffers or causes others to suffer. Categorically, he has a behavior problem with a habit disorder, neurotic traits, conduct disorder, personality defect, educational disability, sexual deviation or intellectual inadequacy, to name just a few of the classifications. He may even have a neurosis or a psychosis. Often the problem, whatever it is, is the result of a disturbed relationship between the child and a parent or parents, or parent substitutes.

To identify such a child, we might ask ourselves several questions:

Does the child enjoy reasonably good physical health?

An example of a child who does not enjoy good physical health is a 6½ year-old-girl who was born premature. She has had irregular convulsive seizures, mumps, very frequent colds with fever, tonsillitis, a virus infection with mastoiditis and deformed heels. It is easy

to see how this child can have a distorted self-image. It is easy to see how much parental anxiety and concern would revolve in and about this child which might express itself in indulgence and over-protection making problems for both the girl and her parents.

Is the child's behavior suitable for his age?

An example of behavior unsuitable for his age is a 6-year-old boy who is emotionally immature. He clings to his mother and cries every time she leaves him even for short periods. He is able to dress himself but wants his mother to do it for him. He talks with a lisp and is hard to understand although his mother states she can understand him. When he is with children, he always wants to have his own way and has temper tantrums even when minimally frustrated.

Is his response to a situation appropriate?

An example of inappropriate response to a situation is the 9-year-old boy who is terrified of going to school. The children like him and he gets along well with them. The teachers treat him well and there is nothing in the school situation that is fear-producing. He wants to be with his mother and is afraid to be out of her sight.

Does he act in a way which is consistent with his personality?

An example of inconsistency in personality is a 4-year-old girl who after a serious infection with high fever changes from a rather easy-going, reasonably conforming, somewhat placid child. She becomes overactive, nervous, destructive, and inattentive.

Is the child generally happy?

The unhappy child is morose, perhaps restless, moody, unsmiling, withdrawn. She may be quite shy and timid or constantly having to pick on other children or fighting.

Can the child's parents cope with the child and are they able to deal with him?

On many occasions we have parents say to us, "I don't know what to do," "I'm at the end of my rope," "My child is beyond me," etc. The parents feel helpless and powerless to deal with the child.

If the answer to these questions is "no", then the chances are that the child is emotionally disturbed and needs help.

Disturbed Relationship

I have said that generally speaking, the parent-child relationship of a conflicted child is a disturbed one. People do not live in a vacuum. When a person has emotional problems, there is a reason and this reason can often be found in the relationship with people important to that person. In the case of a child, the people most important to him are his parents and other members of his family. If this relationship is disturbed, emotional difficulties may follow. This comes about roughly in this way: Children have emotional needs such as the need for love, affection, security, independence and individuality and learning new experiences. If these needs are not adequately met or fulfilled, anxiety develops and problems may follow. In essence, a disturbed relationship comes about because the emotional needs of the child have not been taken care of adequately.

The causes of a disturbed parent-child relationship are many. Clues to finding such causes are knowledge of the follow-

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BELONGING PAYS DIVIDENDS

MANY people, particularly young people, lack activity that could help them maintain their mental health. The psychiatrist can wholeheartedly recommend belonging to one or more groups in the community, participating in community activity, with a guaranteed return directly proportionate to the investment, for the timid and the bold and all those in between.

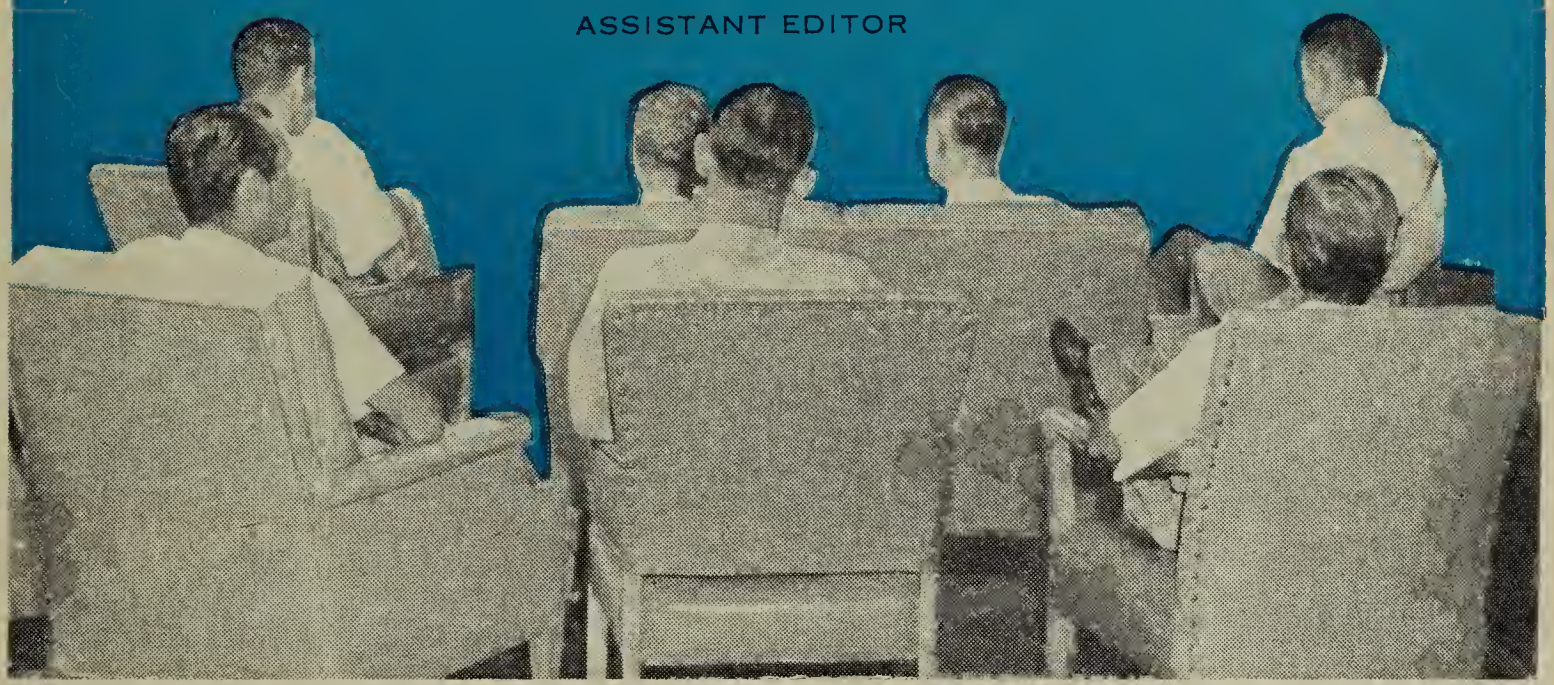
—William C. Menninger, M.D., in *Psychiatry in a Troubled World*

PSYCHOTHERAPY

THE ART OF UNDERSTANDING

Listening, understanding, suggesting are tools psychiatry uses to help people solve problems.

BY GEORGE ADAMS
ASSISTANT EDITOR



ALL of us know how good it feels to "get a load off our chest" occasionally. Unburdening ourselves of pent-up worries and problems helps keep us mentally healthy. Just being able to "sound off" to someone—a wife, husband, or even a good friend—seems to relieve our mental distress and restore our peace of mind. When we bring our problems into the daylight and talk about them, they don't seem half so overpowering as when we let them boil around inside of us. Talking about them isn't the only way we rid ourselves of anxieties. Some people leave their worries on the golf course, or plant them in the garden, or cast them off with their favorite fishing lure.

When the pressures of daily living build up, as they do in all of us, we have to find release of some kind. The emotionally mature person finds several acceptable outlets for relieving mental distress. But the alcoholic does not seem to be able to react to emotionally upsetting situations in a mature manner. He finds his only release in a bottle. Alcohol becomes his father-confessor, his understanding friend, and his only diversion. Only under its influence can his deepest feelings be expressed.

No Mystery

Psychiatry has provided the alcoholic with a means of getting a load off his chest without resorting to alcohol. The method is known as **psychotherapy.** There isn't anything veiled or mysterious about it. Psychotherapy involves talking about oneself and one's problems. But its method involves more than an airing of immediate problems. It stimulates the patient to probe beneath the surface of his obvious problems into their not-so-obvious roots which lie in the "forgotten" memories of childhood, memories which exert a powerful influence on both happy and unhappy personalities.

Like other people, the alcoholic needs

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PERSONALITY FACTORS IN PROBLEM DRINKERS

BY LORANT FORIZS, M.D.
CLINICAL DIRECTOR
N. C. ALCOHOLIC REHABILITATION CENTER

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Alcoholism is but a symptom of deep-seated personality discomfort.

AN ever broadening body of knowledge indicates that the causes of alcoholism lie in the physical, mental, and emotional aspects of the individual personality. Of these, the emotional structure, the pattern of life adjustment, and the traits of character are apparently most significant. Like our bodies, our personalities have a fairly well defined anatomy; and like our physical structure, our mental structure has an embryologic or developmental phase.

Space forbids a detailed discussion of the different theories of personality development. Using the psychoanalytic approach, however, I will attempt to describe the personality factors that appear to be relevant to the problem drinker. There is much that we do not know about personality. Regarding the alcoholic, the specific aspects of this question are even more obscure.

There are several cultural patterns that must be related to the occurrence of alcoholism within certain groups. From the vast body of information on that subject which has accumulated I want to point out one little sector—that relating to the Jewish culture.

We know that the occurrence of chronic alcoholism is rather low among the Jewish people. That fact, of course, is just as important, from our point of view, as is the high incidence in any other group. What significant facts about the Jewish people do we find besides the low incidence of alcoholism?

Turning to the much discussed topic of personality, one finds that there is a so-called oral phase. On this level of emotional development are conflicts and solutions to conflicts. If something goes wrong at a later stage of development, the person is liable to regress and gratify himself on the preceding level of adjustment—in this case, let us say, the oral phase.

Obesity

What oral elements can be observed among the Jewish people? The absence of alcoholism might be one. The incidence of obesity and diabetes among them, however, is notably high. I think the official estimate of the differences between the Jewish and non-Jewish groups with regard to diabetes is somewhere in the ratio of 1 to 6 or 7.

Here is a sector of the population that apparently has about the same conflicts

in the oral phase as does everyone else, and will probably experience the same frustrations in the later stages of personality development. In the presence of a neurotic process, however, instead of overdrinking the Jewish people tend to overeat. Since the connection between obesity and diabetes is quite well established, this may explain the deviation into obese diabetics. We are dealing here with a notably obscure picture, of which there are merely the vague outlines.

Let us now see what factors in the alcoholic group pertain to oral elements. Is there any evidence that overeating may be used as a substitute for overdrinking? A visitor to an AA club is amazed by the amount of Coca-Cola, together with sweets and coffee, being consumed. Moreover, members are advised in AA literature to keep some sort of candy or sweet at hand to eat whenever the urge to drink comes. It is said this device will cause the craving for alcohol to diminish, if not subside.

Another fruitful field of investigation is a typically alcoholic psychosis, such as delirium tremens. What type of hallucination is found in delirium tremens? Frequently encountered among the contents of these hallucinations is attack by animals, and as a rule by animals that attack by mouth, such as dogs, cats, snakes, and insects. I have never heard yet an alcoholic with delirium tremens describe a hallucination in which he was kicked by a horse. The means of attack in that case would be the foot. Hallucinations of attack by dogs, snakes, insects, and the like may be said to represent aggression by mouth—not the alcoholic's own mouth, but aggression on the part of the outside world coming almost exclusively by oral ways and means.

Feeling Of Dependency

Let us now move from the oral to a higher level of development. After breathing, our first contact with the outside world is by the mouth—through the act of sucking. Sucking immediately suggests the mother and an awareness of dependency on the mother. This feeling of dependency undergoes a great number of conventional frustrations, as a consequence of which, and possibly as a defense against which, we start to develop independence, to get away from mother.

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WIVES OF ALCOHOLICS . . . . . SUFFERING SUSAN

"Oh, I don't suppose I can complain, Hazel, what's new with you?"

Some women marry alcoholics because of their own need to devalue, to hurt, to control, or suffer.

WIVES OF ALCOHOLICS

BY THELMA WHALEN, M.S.S.
EXECUTIVE, FAMILY SERVICE AGENCY
DALLAS, TEXAS

Condensed from Yale Quarterly Journal of Alcohol Studies
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THE alcoholic marriage is a marriage, and as such is not exempt from all the things that are true of other marriages even though it is often discussed as though it were. Men and women marry in an effort to meet their own needs. The needs for which the husband and wife seek satisfaction are complex and varied and represent different degrees of maturity in different individuals. When people verbalize these needs, they usually describe them in such terms as the need to love and be loved; to care for and be cared for; to have a home, children, and companionship. There are other needs, unconscious and unexpressed, which may motivate a man or a woman to marry. These may include the wish to depreciate, to control, to hurt, to seek pain or to suffer. These needs, both conscious and unconscious, occur in a variety of combinations. But each individual has a dominating characteristic which is the nucleus of his personality. It is this dominating characteristic which governs his selection of a marriage partner. In some way the person he selects must appear to him to be the person who can meet his particular needs. This is not to imply that people go about getting married in a thoughtful, reasoned way. They obviously do not. It is their feelings toward another person that guide them, and many of these feelings they do not understand or interpret accurately because they are unconscious feelings.

The woman who marries an alcoholic or a man who subsequently becomes an alcoholic is usually viewed by the community as a helpless victim of circumstance. She sees herself and other people see her as someone who, through no fault of her own and in spite of consistent effort on her part, is defeated over and over again by her husband's irresponsible behavior. This is certainly not true. It merely appears to be true. The wife of an alcoholic is not simply the object of mistreatment in a situation which she had no part in creating. Her personality was just as responsible for the making of this marriage as her husband's was; and in the sordid sequence of marital misery which follows, she is not an innocent bystander. She is an active participant in the creation of the problems which ensue.

Counseling Of Wives

Let us look at some of the women who come to a family service agency for counseling in relation to the problems of being married to an alcoholic.

The first of these women I shall call Suffering Susan because it is clear that her need to punish herself is the dominating characteristic which forms the nucleus of her personality. That was why she chose a marriage partner who was obviously so troublesome that her need to be miserable would always be

gratified. Her husband's alcoholism usually insures hardship, which she bears with composure and equanimity. He usually earns and supports poorly. He may be abusive; he is sure to be irresponsible. When she starts to have labor pains he is never around to help her get to the hospital. And when the baby is born he cannot be found anywhere. He found the strain too great to bear, became gloriously "lit," and is now sleeping it off—heaven knows where.

Good Housekeeper

Susan, however, is a model of deportment. She is a good housekeeper and feels great responsibility for homemaking. She sees this as her proper womanly function and may be so exclusively devoted to practical aspects of planning and management that she is not aware that the home is a cheerless place for husband and children. She is likely to be drab and colorless in appearance and manner. She has few contacts outside the home because of her limited self-regard and self-assertiveness. She is unable to reach out for what are usually called the good things of life. She is invariably apologetic in the way she relates to the counselor, sometimes expressing concern about "taking so much of your time." She presents a picture of uncomplaining endurance in dealing with intolerable situations. Susan does not see problems accurately but presents them in a roundabout, devious manner. She interprets them in terms of unfortunate situations or conditions, quite beyond her control, and for which no one is really to blame. It is from this manner of presenting her situation and from the fact that the problems are of long standing that we sense this woman's need for discomfort and suffering. She feels that there is "goodness" in this meek, self-effacing attitude and manner. To her, the pronoun "I" is spelled a-y-e.

The parental attitudes are particularly confusing to children in these families. Daughters are prone to develop the pain-seeking patterns laid down by their mother. The boys, with such a faulty pattern in their father, are likely to assume a dependent relationship with their mother, for a child needs someone to cling to.

Susan does not always choose an alcoholic for a husband. Her need to be miserable is sometimes served just as effectively by marrying a sadistic, belittling man who is a strict teetotaler and a deacon in the church; or a man who is handicapped physically or intellectually or both; or one who is ineffectual in some other way.

In working with these families, planning may include the use of a variety of community resources, particularly for the children. But the central focus is on helping Susan to understand her own need to suffer, why she has it and how it operates to the disadvantage of everyone in her environment. She needs much help and encouragement in order to do this, and the counselor makes liberal use of psychological support in helping Susan develop self-esteem and self-confidence.

Controlling Catherine

In a different category are the alcoholics who wake up some fine morning and find themselves married to Controlling Catherine. Catherine is quite a girl. She knew all about his drinking but knew things would be different once he had her to look out for him. And she looks out for him. She dominates each and every aspect of their life together. She does this because there is no doubt in her mind that, of the two of them, she is more capable of making decisions than her husband. Generally speaking, this is quite true, too. The unique character of this relationship lies in the fact that, in spite of the affection, sympathy and compassion implied in the act of marrying someone who needed her, this union serves as a vehicle for expressing Catherine's distrustful,

POINT OF VIEW

In this world there are only two tragedies. One is not getting what one wants, and the other is getting it.—Oscar Wilde

WIVES OF ALCOHOLICS - - - - - WAVERING WINNIE

"I *know* I had him arrested, but, Your Honor, he *promised* never to touch another drop."

resentful attitudes toward men in general. She could not possibly have wanted to marry a more adequate man. It would have been too threatening to her. In her view of life, men have all the advantages anyway. Why risk marrying one over whom you do not have some advantage? Consequently her husband's ineptitude is not only acceptable but even gratifying—up to a point. Controlling Catherine always marries a man whom she feels to be inadequate or inferior in some way. He is not always an alcoholic, though he frequently is. Sometimes he is a cripple, or a person with less education or a poorer social background than her own. Or he may be a person of a different racial or national background, in which case Catherine can look down on him because he is "different" and therefore, to her, inferior. We meet Catherine quite as often in the so-called mixed marriages as we do in the alcoholic marriage.

She Takes Over

When Catherine's husband is an alcoholic he tends to become more and more incapacitated as the marriage continues. Economic insecurity usually is present as a result of irregular work. Catherine usually decides to take a job herself, and having done so, she controls the family purse strings with an iron hand and uses this as a further means of monitoring her husband. Unlike Susan, Catherine is highly critical and resentful of her husband's behavior. There is no doubt whatever in her mind who is at fault for the family problems. Has not her husband told her in one of his fits of repentance that he is not good enough for her? She tends to be coldly angry in presenting her complaints and problems, and there is a quality of hardness and unforgivingness in her manner of expressing criticisms. She wants her husband to change and to act differently; to stop drinking and to support her more adequately, so that she may have a happy marriage. Before she comes to us, she has usually sought an ally in a clergyman or a lawyer. She does not look to herself or to her own behavior and attitudes for possible explanations of her situation.

In order to help Catherine to achieve some degree of understanding of her own feelings and motivations, the counselor has to look beneath the surface behavior and see her fearfulness, her anxiety and her strong dependency needs. Not until she feels secure in the relationship with the counselor, however, does she have the courage to examine her feelings. Treatment ordinarily continues a long time, usually a year or more with weekly interviews. The predominant techniques used with Catherine are clarification and psychological support. Under favorable circumstances, with the husband receiving psychiatric treatment at the same time, some of these families can be helped to more stable and improved family functioning, but the very nature of the problem—Catherine's lack of warmth and her inability to appreciate people except in terms of their serving her purposes and meeting her needs—indicates that the outlook for this kind of marriage is not good.

Here, again, alcoholism is merely a red herring. We can, and just as often do, find the same family problems existing wherever Controlling Catherine chooses a husband, whether or not the husband has ever taken a drink.

Wavering Winnie

Next there is Wavering Winnifred. We see her more often than either Susan or Catherine, and she is usually married to an alcoholic. Winnifred appears to be the balance wheel of the family. It is she who gathers up the pieces and holds the family together when her husband is on a spree. She manages the money. She knows how to plan. She has worked outside the home at various times ever since the beginning of her marriage, and her earnings have helped to meet the payments to the building and loan company and the doctor. Sometimes she loses patience with her husband and takes him to court; but the judge, if he takes her seriously speedily discovers that she didn't mean it because she relents almost at once and begs him to dismiss the case.

She may separate from her husband for a few weeks or months, but she

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WIVES OF ALCOHOLICS . . . CONTROLLING CATHERINE

"Now that we're married, Homer, I feel that this is an opportune time to let you know how I *really* feel about things—your drinking, for instance."

WIVES OF ALCOHOLICS - - - - - - PUNITIVE POLLY

"Now remember, when I get home from work, I expect to find the house clean, dinner ready, and you sober."

Like other people the alcoholic needs warmth and understanding instead of reproach and judgment.

TOWARD UNDERSTANDING ALCOHOLICS

BY ARTHUR LERNER, Ph.D.

COUNSELOR, LOS ANGELES
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GENERALLY speaking, a mature person is considered to be one who is able to establish adequate and wholesome relationships in the areas of the family, the world of work, and in his social experiences. Furthermore, the mature person seems able to effect such relationships with a reasonable degree of self-confidence and security and with a minimum of doubts.

It is desirable to point out, however, that no single individual is a perfect example of maturity. Furthermore, maturity is not acquired through inheritance. Rather, it is a state of achievement—constant achievement—one which can only be continually attained.

Among the distinguishing marks of a mature person is an awareness of an undue use of excuses or rationalization for inappropriate behavior patterns. It is true that the mechanism of rationalization is universal in scope. It is employed by people everywhere in the course of their daily existence. Furthermore, it has also been suggested by research workers in the study of human personality that a modicum use of rationalization or finding reasons for one's behavior is a normal and vital part, in many instances, of preserving one's equilibrium.

The mechanism of rationalization is believed to be a phenomena which can manifest itself consciously and/or unconsciously. However, in whatever form it may present itself, it can become a real problem when the excuses or reasons one gives for his behavior or feelings interfere with his well-being physically, mentally, emotionally, and socially. In this respect, the alcoholic is an expert at finding "reasons" for drinking.

The alcoholic is primarily a human being beset by many problems. In his attempt to solve these problems he tends to use the mechanism of rationalization to a marked degree. "One drink more, it won't hurt." Nobody cares, anyway." "No one understands how I feel." "I'm not an alcoholic; I'm a social drinker and can quit anytime I want." Etc. etc. All of these remarks indicate unrealistic attitudes in facing oneself. It has been observed on numerous occasions that no matter how many friends, family members and professional people may desire to understand and to help the alcoholic he will frequently give vent to immature expressions of behavior in order to carry on his drinking habits.

Difficult Task

In breaking away from excuse-making the alcoholic faces a most difficult task. There is often backsliding into old habits. There are many gnawing doubts and hostile feelings. Nevertheless, with each new victory to "stay off the bottle" comes a strengthening of the desire and of the ability to achieve further victory. Of course, this is most likely to be the case when the alcoholic "translates wanting to help myself" into constructive channels—with help.

Alcoholics need help in learning how to help themselves. In spite of numerous

beliefs of the contrary, not all signs of resisting help means that the individual is refusing help. The alcoholic, like the infant, has to learn to walk—emotionally—all over again. Doubts and frustrations are quite often normal concomitants of any learning or relearning experience. In breaking with old habits and ways the alcoholic will feel his share of anxieties.

Those of us who work with the alcoholic do well to keep in mind at all times that it is precisely at moments when doubts, frustrations, and insecurities are beginning to crop up that the alcoholic **can be helped** to gain further understanding and insight into his situation. The outward signs may be discouraging, but the inward growth of the alcoholic can be quite rewarding, leading to effectiveness in meeting his problem.

Special Responsibility

For those of us interested in helping the alcoholic to help himself, a special responsibility ensues. We should become aware of our own rationalizations. This means a conscious understanding and realization that the alcoholic is not necessarily a "bad" person. Referring to an alcoholic as "bad" or "weak" is in and of itself no explanation of his problem. It may indicate more of a projection of our own biases. We can certainly understand without blaming. For we render a disservice to our fellow man when our own emotional blind-spots hide from us the true nature of their physical and emotional make-up. For in one respect we are all alike—alcoholic and non-alcoholic. Warmth, affection, and a feeling of being wanted and recognized appear to be our common needs. In the final analysis, by accepting and understanding the alcoholic and his problem—without judging him morally—we are revealing a breadth of understanding which the great of all ages have displayed.

Personality Sketches

(Continued from page 6)

was continually aware of the very limited facilities in England for helping alcoholics arrest their illness. It seemed, too, that most of his British colleagues neglected the personality factors in the illness of alcoholism. Ewing was convinced from his studies and from his own experience that alcoholics were suffering from a personality illness. Treatment which largely neglected the personalities and emotions of the alcoholic patients seemed to him to be something less than effective.

Ewing's feeling of frustration at the limited facilities for working with alcoholics was partly responsible for his decision to look to more promising fields for service in his profession. America, with its growing awareness of the problems of alcoholism and mental illness, plus its shortage of trained psychiatrists claimed his attention as he began thinking of his future. Dr. Murdoch's ad soliciting applications for positions at Butner put in a timely appearance in one of the English medical journals, and the young psychiatrist promptly submitted his qualifications for Murdoch's consideration. Imagine his surprise when Dr. Murdoch's reply of acceptance was postmarked Durham—this time in North Carolina!

The Autumn of 1951 found Dr. Ewing, his wife and four-year old daughter settled in their new home at Butner, where the Scottish psychiatrist took up his new post as senior physician on the Butner State Hospital Staff. He wasn't there long before Dr. Lorant Forizs asked him to serve as Forizs' first assistant at the Alcoholic Rehabili-

ONE winter night an inebriated gentleman wandered into the cemetery and fell into an open grave. Unable to climb out, he screamed for help and finally attracted the attention of the superintendent, also under the influence.

"Let me out of here," he said, "I'm freezing!"

"No wonder," replied the superintendent, "you ain't got the dirt pulled over you."

tation Center. Dr. Ewing's eyes sparkle when he recalls that he was "really excited at the prospect of working at the Center. "I was thoroughly in agreement with Dr. Forizs' philosophy of treatment, and it was quite a satisfaction to know that we would be able to treat the emotional factors which I had long felt to be at the base of the alcoholic's drinking problem."

The best proof of Dr. Ewing's effectiveness at the Butner Alcoholic Rehabilitation Center can be found in the glowing terms with which patients describe him. In the words of one patient, "That Dr. Ewing understands us alcoholics inside out." High praise indeed from one who typically feels that he is understood by no one. Clinical Director Forizs, too, has appreciative words for Ewing. As he put it, "John's sincere interest in the individual patient, linked with his keenness for research make him a very valuable man at the N. C. Alcoholic Rehabilitation Center."

Enthusiastic

Dr. Ewing radiates enthusiasm when he speaks of the role of psychiatry in helping unhappy people find happiness. Alcoholics, those with more severe mental illness, and people with less severe personality problems, which, nevertheless cause much unhappiness and lost effort —he sees all these as potential recipients of the kind of help which psychiatry can give. "I like to have the opportunity of communicating my enthusiasm about psychiatry." he says, and therefore counts his part-time teaching experience at Chapel Hill as "highly satisfying." "It is encouraging," he notes, "to see the interest in alcoholism being shown by young medical students." He regards this as just another sign of the hopeful future for alcoholics here in North Carolina.

In strong contrast to his career dealing with the intangibles of the mind, Ewing finds relaxation and diversion in tinkering with automobiles. "When there is trouble with a car, you can jerk the cylinder head off and have a look inside," he notes with obvious relish. You can't do that with a patient who has troubles. I find that a good knuckle-barking turn with a wrench and pliers relaxes me and sends me back to my patients with renewed understanding and patience."

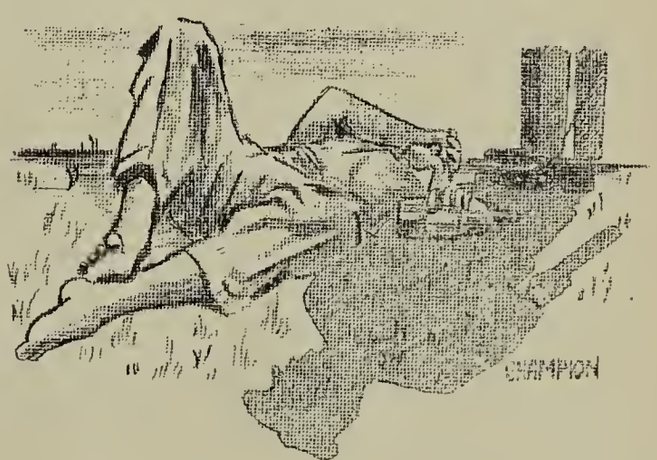
Coincidental as was Dr. Ewing's move from Durham, England to Durham, N. C., there is nothing accidental about his achievements since arriving here. Sound education, versatile training and experience, a deep regard for the value of the individual personality, and a keen and inquiring mind ever alert to new truths— these are the qualities on which Dr. John Ewing is building an outstanding career of service to North Carolina's emotionally ill.

Psychotherapy — The Art of Understanding

(Continued from page 9)

to be able to express his deepest feelings and emotions, his pet hates and his secret loves. Somehow he seems never to be able to express these feelings without the crutch of alcohol, and then he is judged harshly as a rule. Psychotherapy encourages him to say what he feels without fear of judgment or condemnation. Psychotherapy is the art of understanding. A friend who listens to your troubles sympathetically is using the healing power of psychotherapy.

This is a novel experience for the alcoholic. For a long time he has been on the receiving end of practically everybody's abuse and criticism. Nobody ever asked him what he thought or how he felt. He wasn't supposed to have an opinion. His wife has berated him time and time again for neglecting her and



the children. His mother-in-law has scorned him for ruining her daughter's life. The preacher has possibly lectured him about his "sinfulness." The boss has admonished him to "get hold of himself" or lose his job. The alcoholic knows all these things are true, but he resents other people telling him. People just don't sit down with him and say sincerely, "Look Joe, I know you've got a lot on your mind. Tell me about yourself, boy." Imagine his relief at being put in a situation where he can do all the talking. Psychotherapy gives him this opportunity. While the alcoholic airs his problems, the psychiatrist takes the role of understanding friend, listening sympathetically, suggesting possible solutions, but never criticizing or condemning. Is it any wonder that an alcoholic's mental state improves under such an atmosphere?

Verbalizing

Why does his mental state improve, and his chances for continuing sobriety improve as well? Because for perhaps the first time in his life the alcoholic is putting into words some of the heretofore nameless problems that continually fan the flames of his addiction. As human beings we deal largely in words. Words are the verbalized expressions for thoughts, for emotions, for feelings, for anxieties, for problems. Only by expressing thoughts in spoken words can we deal with them realistically. The alcoholic, then, by expressing his disturbing feelings and emotions through psychotherapy, can begin to explain them and clear them away. Some insight into the source of these feelings helps to relieve the mental distress which accompanies alcoholism.

The relief which the alcoholic gets from talking about immediate troubles and worries is obvious and genuine. But the roots of his problems go so deep that he needs more than just a superficial airing of his difficulties. The real roots of the alcoholic's problems lie in a succession of childhood experiences. Memories of these experiences have been pushed below the surface of consciousness, usually because they may be too uncomfortable or too unpleasant for the individual to face. These repressed memories do not just pass out of existence. They find hiding places in the unconscious mind where though "forgotten," they produce the unhealthy attitudes and immature reactions which help to shape the alcoholic personality. In psychotherapy, the alcoholic patient is encouraged to root out these truant memories from their hiding places and shove them up into the light of day where they may be talked about, examined, and understood.

Group Psychotherapy

Psychotherapy may be on an individual basis where the patient talks with the psychiatrist alone, or it may be participated in by a group of people under the guidance of the psychiatrist. The group method of psychotherapy is the principal method used with alcoholic patients at the N. C. Alcoholic Rehabilitation Center. Group therapy sessions are the very core of the Butner treatment method for alcoholism. A movie explaining some phase of personality development precedes each session. Patients are then encouraged to

UNDERSTANDING AND EFFORT

ALCOHOLISM is a chronic condition. As such it can be controlled only as the person lives and deals with it every day, working out satisfactions and understandings and devices which will make it possible to stay sober. Treatment may last many years, and members of the alcoholic's family must recognize that care may take a long time. While this may seem at first a tough assignment actually it becomes a means of increasing happiness and orderly living.

—Ernest A. Shepherd, Administrator, Florida Alcoholic Rehabilitation Program

discuss the movie. It isn't unusual for alcoholic patients to come up with a remarkable flash of insight into their own problems by linking their own childhood experiences with those seen in the movie.

It Isn't Easy

For alcoholics, group psychotherapy offers advantages over individual therapy. The old adage, "There is strength in numbers," certainly applies to the group method of treatment, whether in group sessions at Butner or regular meetings of AA groups. It isn't easy for anyone to talk about something as personal as his feelings and emotions. So many alcoholics have been thwarted from expressing their real feelings over such a long period of time that it is a tough job to break down the old roadblocks to free expression. But knowing that one is in the company of others who have similar problems and feelings makes it easier to talk about one's own. The friendly, accepting atmosphere of the group therapy sessions helps alcoholics to free hidden feelings and encourages patients to talk about anything they wish. It has been demonstrated that many alcoholics make better progress in group therapy than in private interviews with a psychiatrist.

Inferiority Feelings

Part of the success of the group method may be explained by the feelings of inferiority which all alcoholics have in varying degree. Alcoholics suffer from a deep sense of inadequacy, of being different from others, of being weak characters. Their confidence takes a spurt upward when they discover they are on an equal footing with others. The group develops a *morale,* an *esprit de corps* which helps members to bear each other's burdens and to accept suggestions they couldn't take from anyone else. This same spirit of equality coupled with a hearty respect for the other fellow has been incorporated with great success into the Alcoholics Anonymous program for sobriety. In group psychotherapy, as well as in AA, there is no room for judgment or condemnation. The feelings of the individual are what count.

Butner patients respond enthusiastically to group psychotherapy. One woman, near the end of her 28-day treatment said, "When I came to Butner, I felt like I had the weight of the world on my shoulders. But after being in on a few of the group discussions, I found out that the others had problems just as bad as mine, and some even worse. It made me feel like I could talk about mine without anybody looking down their nose at me."

Another patient, a man, remarked, "Being in those group talks helped me more than anything else in the world. For the first time in my life I feel like I understand why I drink and can do something to control it. I believe with what I have learned I can go home and stay sober."

A young fellow, his bag packed for the trip home, had hearty praise for the group method. "I never could have admitted to myself the things I have if I hadn't felt sure I could say anything I wanted to without having somebody jump down my throat. It really helps to know that everybody else at the treatment center is in the same boat with you."

These comments are fairly typical of the things that alcoholics have to say about the group psychotherapy method of treatment for alcoholism. A few patients miss the point completely and complain bitterly that they came for "treatment" and not to see movies and have "gab sessions." A good percentage of alcoholics who come to Butner do gain a surprising amount of insight into their illness. Many gain more self-knowledge by joining another therapy group at their nearest Mental Hygiene Clinic on returning home. All alcoholics are sure to encounter emotional growing pains in their efforts to adjust to a life without alcohol. But group psychotherapy is giving many the kind of understanding of their problems that can serve as a solid foundation for sobriety.

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Glasses affect vision, particularly when they have been emptied several times.—from **Mutual Moments**

Is Your Child Emotionally Disturbed?

(Continued from page 8)

ing:

What the parents are like.

What they expect of themselves and each other.

What they expect of the child.

What the child is like.

What the child expects of his parents.

What he believes they are and what he believes they expect of him and expect him to be.

The actual causes may include:

Excessive parental control.

Marital tension and discord.

Mental illness in parent or parents.

Parental over-indulgence.

Parental over-protection.

Inconsistency of discipline.

Lack of limitations.

Successive traumatic happenings to the child.

Parental rejection.

Excessive parental expectations and demands.

It is to be noted that most of these causes involve either an excess, a lack of, insufficiency or inconsistency of attitudes.

Examples Of Attitudes

What are attitudes? They are tendencies to act, think and feel. Examples of attitudes are the tendency to believe Johnny is lying whenever he tells you something; thinking that Anne is a perfect child, therefore she cannot do anything wrong or mean; having trust and confidence in your child.

Attitudes of course affect children. They feel attitudes and react to them. The result is behavior which may be desirable or undesirable so far as the parents and the child are concerned. The child's response to the attitude may be intentional. More often, it is unintentional even though it may seem intentional. This is another way of stating that attitudes and reactions to them are conscious or unconscious. One may or may not be aware of them. For instance, parents may not actually be aware that they don't trust Johnny; they may not be aware that they want Anne to be perfect. In turn, Johnny is not actually aware he behaves as he does because his parents don't trust him; Anne is not aware she wants to get all A's in school because her parents think of her as perfect and she wants to fulfill their expectations.

Parental Attitudes

Adverse parental attitudes do not always cause problems in children. Often they do. Sometimes they don't seem to affect a child very much. Sometimes they cause behavior problems. At times they may actually motivate a child to achieve and accomplish. We don't always know why this is. We do know it's true and we have a good idea why a child behaves as he does under a given set of attitudes.

Let us see how parental attitudes cause problems in children. We will take a feeding problem and general fears as examples.

Let's say a mother picks at her food—maybe she's worried about getting fat. Being fat is very unattractive to her. Or else she thinks eating everything is necessary to perfect health and she wants her child to be perfectly healthy. Maybe as a child she herself had little to eat and to her eating has premium value. Let's say the husband gets indigestion when he eats certain foods or

else he's a fussy, finicky eater. He can't eat this or he can't eat that because the food is poorly prepared or unattractive or he had been overstuffed at one time. All of these tendencies are in the nature of undesirable attitudes. The child sees the mother pick at her food. He hears the father being fussy and critical. The result is that the child picks up their attitudes and behaves like the parents in reference to food. He soon learns that what he does in eating has "bargain" value so eating may become an important issue and a problem.

Or take the mother with fears. The mother fears to ride an elevator; she's afraid of lightning or thunder; maybe she's always worried about getting some disease. Or she's deathly afraid of dogs. When she rides an elevator with her child she shows her fear; when lightning flashes or thunder roars she cowers in horror.

Developing Fear

If she gets near a dog she pulls away in fright or when her child goes to pet a dog she jerks him away panic-stricken or yells. The child senses and sees these fears. If someone as big and powerful as mother gets afraid, these things must be dangerous. So the child develops fears; he gets afraid. Then these fears may spread to other things and a problem has been created.

Let's take the whole area of social relationships. In our culture we're all supposed to be popular, we stress how important it is to get along, we're supposed to love our fellowmen, be friendly, outgoing, etc. We shouldn't get angry with anyone, we're supposed to be unbiased, have no prejudices, we must all be equal. For our children to live up to these demands we want them to conform; they are made to take piano lessons, go to ballet dancing, learn to twirl a baton. They should always be polite, they should respect their elders, etc. It's as though merely being an adult is the only reason adults should be respected and honored. These social expectations and ideas are attitudes which in general up to a point are reasonable and necessary in our culture for adjustment. However, if excessive, too rigidly held or used solely to meet prestige and aggrandizement needs of the adults, they can cause problems in the child.

Human Behavior

To help the emotionally disturbed child we need to know something of the dynamics of human behavior and reaction. We have to know the normal child and normal development to recognize the so-called problem child.

Since, as I have said, many children's problems result from a disturbed parent-child relationship, then logically, to help the child, we must also try to help the parents. We try to have the parents gain an insight into the child's problems and their own attitudes which may be involved and through support, encouragement and guidance help the parents to modify these attitudes so that the parent-child relationship is less disturbed. Ideally, this is done by working with the parents and with the child simultaneously. I realize that unless it is in a special setting such as in a guidance clinic that this is not possible. For example, here in the Mental Hygiene Clinic in Raleigh we use the team approach of social worker, psychologist and psychiatrist. The social worker sees the mother or parents at the same time that the psychiatrist or the psychologist under supervision of the psychiatrist sees the child. When it is not possible to work with the parents and the child, help with either can be beneficial.

Sometimes the environment has to be manipulated or the child placed outside his home in an environment more conducive to sounder mental health. This plan should be looked upon as a tem-

EMOTIONAL NEEDS

It is essential to good mental health that one understand basic human emotional needs and drives and the morally and socially acceptable ways of satisfying them.

Sweeney & Dickerson in *Preinduction Health and Human Relations*

porary expedient whenever possible, with the hope that the child can be returned to his home eventually.

In order to help parents, initially we need to help them to recognize the fact that there is a problem. The criteria I used earlier in this paper for recognizing a child with problems can be useful. When the parents can see the problem it is easier to help them. Admittedly it is often very difficult to have parents understand there is a problem. When the parents are quite resistant there may be little we can do except to call their attention to the fact of the problem and wait for a more advantageous time. It does little good to push them or to harass them or to challenge them and make them defensive. This is an area where social workers and school personnel can be mutually helpful. Many teachers need help in how to approach a parent to realize a child has a problem; they may also need help and support in dealing with a child in the classroom. On the other hand, there are many fine teachers who know their charges and their parents and can offer valuable insight into a child's problem and what his unmet needs are. The parents, after recognizing a problem, must accept the fact which may come with recognition and then be willing to do something about the problem.

Our own attitudes are extremely important. We must avoid being critical, censorious and judgemental; at the same time we should be able to empathize to a point with the child and parents. It is easy, because children are so appealing and because we may have strong hidden feelings about our own parents, to identify with the child and think of parents as "bad parents" or adopt the nauseous cliche' that "there are no bad children, just bad parents."

On the other hand, a "problem" child is in reality a child with problems. If we assume that to a large extent behavior is unconscious then it is illogical, unfair and unjustified to censor parents for their role in creating problems. It is also

SHOULD YOU REFER YOUR CHILD TO A MENTAL HYGIENE CLINIC?

YES, if he is chronically unhappy.

YES, if you as a parent, feel you cannot cope with your child and his problems.

YES, if your child's personality and behavior change for the worse.

YES, if your child does not behave in a way suitable for his age most of the time, taking into account that normal growth and development vary rather widely.

YES, if your child's response to a situation is chronically too intense or extreme.

YES, if your child has physical complaints for which the doctor can find no real physical basis.

YES, if your child has a physical or mental handicap to which he is not adjusting comfortably.

impractical, because such an attitude engenders hostility and resistance which minimizes the possibility of help to the parents and therefore indirectly the child.

It is not hard to recognize a need, but whether that need can be met is another matter. Hence, we must have a sound knowledge of the available resources for help on every level and also the knowledge of limitations in effect. A helping goal can be limited and still be very desirable and useful. Changing behavior is a slow process.

A client may react with surprise, resentment, dismay or hostility if referred to the Mental Hygiene Clinic. One can anticipate his concern and say that he is worried that the clinic sees "crazy" people. Actually, most people who go to clinics are not crazy but have personal problems that need help, as when one gets an infection and goes for help. It is helpful for the client to know what kind of help he might expect.

With some parents we may need to spell out a procedure for dealing with a child; with most parents it is necessary to repeat continually a procedure that has been outlined. Chronic attitudes do not change overnight and progress is made oftentimes, not dramatically but in a slow and gradual step-wise fashion with plateaus and backsliding on the part of both the parents and the child. It is important that parents feel they are not being forced or coerced because this may result in unconscious sabotage. Also, if a plan is outlined for which the parents are not ready or unable to execute, then they may feel the helper cannot give help or has little understanding of the problem and movement is hindered. For example, a perfectionistic mother may not change and be just the opposite to her personality but she might learn to be satisfied with her child getting B's in school instead of all A's; an overprotective mother may not be able to allow her child to ride his bicycle to school but she may be able with encouragement, to allow the child to ride his "bike" in front of the house for a short distance. For them, these are "Giant" steps.

"So I says to the board of directors, I says, 'you can't make a bum out of me —your president—just because I go on a little toot now and then'."

What Discipline Means

That we should have a reasonable command of sound mental health principles which we use in guiding parents seems fundamental. Space does not permit a discussion of these principles but I wish to refer for a moment to what we call "discipline." I think it is helpful to parents to know that discipline does not mean simply either "punishment" or "reward." It involves a much broader area which is covered by such terms as "guidance," "training," "sanctions," "permission," "instruction," "prohibitions," and so on. Discipline is a way of treating a child to help him become more mature and more responsible at his *particular stage of development.*

I suppose that actually the best way to help an emotionally disturbed child is to prevent his emotional disturbance in the first place. We may not be able to do as we would like in prevention but we can have prevention as our aim. One very important way is to help parents have confidence in themselves to be good parents and to realize that children can be a joy and not a burden. There is too much emphasis on the "negatives" and not enough emphasis on the "positives" in any relationship. There has been also, I think, too much in the literature which is anxiety- pro-

ducing rather than anxiety-reducing. There has been too great an emphasis on the making of problems and not enough on the readily ascertainable fact that a child is durable and flexible and that the drive to maturity is a tremendously powerful force which is a natural ally of parents and children.

Let us hope then that we can so interpret what we have learned about the mental health of the child that we can help parents to face their children's problems rather than deny and cringe before them: and to relieve their anxieties rather than to compound them.

Personality Factors

(Continued from page 11)

This means leaving the oral plane and trying to operate on a higher level of development.

It is safe to say that in many cases of alcoholism, the patient has had some degree of difficulty in making this transition. The first formula was a feeling of security through dependency. This has to be changed to one of security through independence. The alcoholic, in most cases, is overdependent on his mother and stays so, for some reason, for a considerable length of time. If the feeling is too strong, he may try in some way to deal with it, to compensate for it. He may make a desperate attempt to be overindependent.

Two Mechanisms

A review of a few hundred cases of alcoholism will disclose a great many instances of these two mechanisms—either a prolonged period of dependency or an early switch to patterns of extreme independence. Living by dreams of mother would mean too close an identification with her and her principles, her ideas, her criteria — in short, becoming too much like her. In a man this feeling may, at a very early age, be manifested in the fear of being a sissy. Discovery of this fear may lead to an attempt to be overly masculine. Hence the tremendous number of case histories of patients who became "sexual athletes" long before they touched their first alcoholic drink; and hence the rather pronounced promiscuous features of the alcoholic's early life, which I believe few people would deny.

Adolescence

Note the difficulties some patients have in late adolescence with the "nice" type of girl. Back of it lie such ideas as: "I can't go with these girls; they are too much like my mother, and getting too close to my mother is dangerous." It is fairly obvious that the Oedipus complex has something to do with this difficulty. The patient reasons that his mother, perhaps through overprotectiveness and indulgence, has kept him too dependent on herself; consequently the type of personality which he represents has become intolerable to him. Because she makes him feel that he is a sissy or a baby, he turns to the promiscuous type of girl and acquires the characteristics which are so prevalent in the early history of alcoholism. Many adolescents turn to alcohol during this phase in order to overcome their concern over girls in general.

I have already implied that overdependence on mother is resented—an important factor. This resentment is a form of aggression directed against the female figure. Since the first female figure in our life is the mother, it is in relation to her that the individual lays the foundations of his emotional structure. Furthermore, his relationship to her will be transferred to many aspects of his relationship with the female sex in general.

Let us turn to another alcoholic psychosis—alcoholic paranoia. In an overwhelming number of these cases the contents of the delusions or hallucinations are centered in the faithfulness of the wife. The mechanism, we think, is this:

Only parents who expect to live forever should have perfectly obedient children.

—George H. Preston, M.D., in *The Substance of Mental Health*

"I don't like women, I have had too many unpleasant experiences with them —first of all with my mother—so I cannot tolerate them. But if I cannot tolerate women, I will not be masculine but feminine. Since I cannot tolerate being feminine I will try to be overmasculine.

Projecting Feelings

"I have many promiscuous trends in myself. My wife, if I have one, is so much above me morally, that I am made to feel even lower; therefore, I will try to pull her down; I will project my promiscuity into her. I am no good, but neither is she. Since I cannot master myself, I must attack her. The most feasible means of attack is the projection of my promiscuity into her. This is the only tool I have, and it is close at hand. Perhaps I am too promiscuous to confess even to myself; but if I project this promiscuity into my wife, saying that she is unfaithful to me, my position will be raised, hers will be lowered. If, in my paranoid construction, I make a prostitute of her, we will become closer to each other. Our incompatibility is an established fact. I have reverted all responsibility for this situation, however, by convincing myself that my promiscuity is non-existent. By projection I have placed all the blame on her."

Perhaps the individual is fairly well balanced until he gets married. Trouble may strike only when he tries to adjust to his new situation. It is not necessary to go into the difficulties encountered in the marriage of an alcoholic. I have heard one very good student of alcoholism say: "How could you expect a woman who has been through so much trouble for 12 to 15 years because of her husband not to be neurotic and decompensated?" I believe this to be true, but not the whole truth. I have observed that in the majority of these marriages the personality of the wife is preponderantly maternal. From what has already been said, it is not difficult to see why the man who has had early trouble with his mother and who has passed through a rather stormy adolescence will try to find a mother in his wife. In many cases the wives are older than their husbands—another indication of maternalism. Whatever the man's need to marry a "mother," he would not succeed without the consent of someone who was herself inclined to assume the role of mother. This brings us to the personality of the wife of the alcoholic, which in some respects seems to be as neurotic as that of the alcoholic.

Inadequacy

This man who is inadequately masculine underneath marries a woman who is feminine in only one way—the maternal. Her maternalism is probably her only defense against her inadequate femininity. What happens when they try to live together in marriage? There is growing discord as the man resents anything

SOCIAL DRINKERS AND ALCOHOLICS

WE must distinguish clearly between the drinker who occasionally uses alcohol to excess and the individual who is a true addict. One of the simplest and I think a very good definition of the alcohol addict is that he is an individual who cannot get along with alcohol or without alcohol. Many individuals who occasionally drink to excess can and do stop when and if they recognize that alcohol is leading to harmful consequences. The true addict is unable to stop. He is to be looked upon as a sick person requiring medical and psychiatric care, rather than a moral problem or simply a weakling. A great many alcohol addicts are persons of very superior intelligence, extremely competent and capable of making most important contributions to society.

—Karl Bowman, M.D., Director, Langley-Porter Clinic, San Francisco

which does not satisfy his need of masculinity, while the wife does just the opposite. Slowly they drift apart. In studying the wives of alcoholics, it is interesting to find that in many cases they divorce one man because of his drinking only to marry another known alcoholic. I have in my records cases in which a woman has married five alcoholics in this style. Two or three such marriages on the part of a woman is not rare.

The marital conflict of an alcoholic originates in his psychodynamic structure as well as in the psychodynamic structure of the wife. If he does not reach the level of deciding to marry and trying to make an adjustment, he probably remains a bachelor; becomes a homeless man, the drifter, whose only sexual contacts are with prostitutes. In such contacts, he will never find satisfaction or complete sexual identification.

Burning Problem

Another burning problem apparently originates, to some extent at least, in these same difficulties. "How can I prove to myself that I am a man?" Because of an example which they had before them when they were young, many men find in work their only compensation for not being enough of a man. They work and work and make money. Such people are well known. They might be called addicts of success just as sexual athletes are called addicts of sex. Both represent forms of addiction. The success addict works, not because he wants to work, but because he cannot live without working. He is compelled by a force which is beyond his will power; which is beyond conscious estimation and measuring. He works on account of these deep-seated pressures. He cannot relax. He tries to, especially after he has reached the peak. He may say, "A few drinks will probably help me." And I have no doubt that they do.

The man who is addicted to success, who is pushed towards success, cannot relax without resorting to artificial means. No wonder that he becomes addicted to the relaxant, to the depressant. Since his values are usually much higher, he may not be able to tolerate the end effects of alcohol. Accordingly, he finds a measure of compensation as soon as the first bout has taken place, then, after three months, two years, three years, when enough pressure has been built up again, he will revert to alcohol. I believe that in this form of speculation we may find at least some explanation of the debated and difficult question of the periodic drinker.

Attempts To Compensate

According to those who like to think of personality disturbances or character deviations in dynamic terms, the alcoholic, because of his faulty personality development, suffers from a neurotic discomfort. There are signs of desperate attempts to compensate for the discomforts in the form of certain character defenses. When, at a certain age, these defenses for some reason start to break down, the alcoholic candidate changes from total abstinence or social drinking to addictive drinking. He then reaches for the drug to anesthetize his personality discomfort. The emotional immaturity of the addictive drinker and the scrambled character structure which results from it, plus the pharmacologic aspect of alcohol, precludes further emotional growth. In fact, the action of alcohol enhances regression. Alcohol, in this

WARNING SIGNALS

SNEAKING DRINKS

respect, meets the regressive needs of any neurotic. Speaking in figurative terms, the alcoholic, when intoxicated, is operating on an infantile level, whereas, when sober, he is a very uncomfortable child in an adult body and in an adult world.

Taking this fundamental principle into account, I would point to the relatively neglected significance of the drunken behavior of the alcoholic. According to Strecker, it is almost always possible to detect in this behavior a nucleus which indicates the focal conflict of the individual and his immediate and most primitive defenses against it. Thus the "crying drunk" appears to represent the "lost child"; the intoxicated sexual athlete is trying to compensate in a pseudo-masculine way with frequent heterosexual contacts for his vague awareness of predominantly feminine identification; the fighting drunk reflects the conflict with figures of authority, usually originating in early conflict with the father.

No matter how sketchy this presentation may be, if it enables the physician to take a closer look at the alcoholic, our patient already has been benefitted.

Wives Of Alcoholics

(Continued from page 16)

always comes back when he pleads with her and makes promises. She does not easily admit love for her husband. Her friends and relatives have told her that she is a fool to stay with him, and she fears that the counselor may have the same opinion. Her "official" position is, therefore, that her husband's behavior has killed her love for him. When she has learned to trust the counselor, however, she will express verbally her continuing affection for her husband. If he leaves home, she expresses great anxiety about his comfort and safety. Suppose he should get run over when he is not quite himself? Winnifred seldom expresses this affection in ways that would really help this man to work out his problem. She shares her husband's blindness about the depth of his difficulties, and she resists, almost as much as he does, any suggestion from the counselor that these difficulties, if untreated, will continue to recur. When he is drinking, she is furious and despairing; when he is sober, she recovers her good spirits, tries to forget the past, and expresses a childlike hope that this time he will keep his promises and there will never again be any trouble.

Affectionate Mother

Winnifred appears quite capable when conditions are favorable. She is a good housekeeper, an affectionate mother, and keeps her family well organized. She is likeable, good natured and pleasant. She has a pseudo-capacity for relationships —"pseudo" in that it gives the outward appearance of genuine motherly interest in both husband and children. Actually, out of her own great need to be loved, appreciated and given to, Winnifred searches out the weak and helpless to form relationships with. She can be giving only to those who seem to need her. She always chooses a husband who, to her, is weak, who she thinks "needs her" and would therefore be unlikely to leave her. As long as she can be sure that a man cannot get along without her, she can feel secure in a relationship with him. The fact that he is also often an alcoholic appears to strike her as a surprising but somewhat irrelevant factor. Basically, Winnifred is fearful and insecure. She is unable to reach out for relationships with adequate, self-sufficient individuals because, since they have

A TAVERN keeper was awakened at midnight by heavy pounding on his front door. Irritated, he shouted, "Go way. You can't have anything to drink at this hour."

"Who wants anything to drink?" was the response. "I left here at closing time without my crutches."

no need of her, she doubts her ability to hold their interest. Alcoholism increases her husband's need of her, and that is why Winnifred can be tolerant of it for a long time. It sometimes looks as if she expects him to drink, although she may fuss and nag about it. When it continues for a long time, or is markedly excessive, however, her tolerance wears thin. She becomes disturbed and disorganized as the situation gets too far out of control—when her husband stays away from home too long drinking, or when he has lost one job and is slow about finding another and the creditors get nasty. She sometimes leaves him under stress of this kind, but her own need for love, appreciation and emotional response is so great that she is quite unable to resist his urgent plea for her to return, to make a fresh start. Wavering Winnifred can always believe what she wants to believe. She doesn't always marry an alcoholic, however. Sometimes she chooses a man who is a steady, faithful worker and quite responsible about holding a job but so dependent and passive in nature that he never gets a promotion and would be the last man in the world to request a raise. Such a marriage usually works out satisfactorily in most respects except for the fact that there are always financial worries and economic deprivation.

Winnifred's children also have felt effects of her need to be needed. Outwardly they are likely to be well-behaved, well cared-for children who achieve satisfactorily in school. The boys may have a rough time of it because of their close tie to their mother and their lack of a strong successful father to pattern after.

In counseling with Winnifred, one of the first goals is to bring about some understanding of the values for her in this marriage, and an acceptance of the "all rightness" of her continuing love for this husband of hers. When she is reasonably intelligent, her protective impulses toward her husband can be mobilized in a more constructive fashion than she could achieve alone. The outlook for improvement in these families is quite good when breakdown is not too far advanced.

Punitive Polly

Last, but not least, there is Punitive Polly, whose relationship to her husband resembles that of a boa constrictor to a rabbit. Such a relationship is often mutually satisfactory; some rabbits seem to like being swallowed. But quite often the rabbit rebels and goes out and gets drunk. Punitive Polly is often, though not always, a career woman. Sometimes she is a clubwoman. She either earns more money than her husband, or it is her influence and maneuvering which gets and holds his job for him or is responsible for the orders or accounts or contracts given him. Polly's relationships with people in general, and with men in particular, are characterized by rivalrous, aggressive and envious attitudes. This makes for great loneliness, although she is so busy being successful that she is seldom aware of it. Polly despises housework and the care of children and usually succeeds in avoiding them.

Since her goal in life is to achieve outstandingly in business or industry, or perhaps politics, where her chief competitors are men, she naturally feels that men are her chief enemies in the world of people. Obviously she could risk mar-

THE A.A. PRAYER

God grant me the serenity
To accept the things I cannot change,
The courage to change the things I can,
And the wisdom to know the difference.

riage only with a man whom she felt to be vulnerable in some way, as a man. In describing her husband, Polly will refer to him as being "boyish" or "sweet." That is when he is sober, of course. In point of fact, he is quite often several years her junior. But regardless of whether or not he is younger than she, Polly's husband always seems to her to be limited in some way in his essential masculinity. If he did not, she would never have married him. It is not surprising that this appealing vulnerability often takes the form of alcoholism.

Polly does not require a great deal of her husband—at least she thinks not. She is quite willing to earn most of the living, to carry most of the responsibility, to pay the rent and buy the television set. All she requires in return is that the rabbit remain swallowed. She wants him to behave like the becoming household accessory she intended him to be and not embarrass her by going out and getting drunk and waking up in the wrong beds.

She will not insist on his taking care of her adequately, as Catherine does, or require him to make himself over for her. She is willing for him to have almost anything he wants—except his manhood. When he does not meet these modest requirements Polly can be very punitive, indeed. Since drinking is often the only way he can find to assert himself, Polly is never free from underlying angry feelings and her behavior toward her husband is likely to be quite harsh and unforgiving. One such husband commented, "My wife is stronger than I am—she's got me down." In this marriage Polly finds an outlet for her aggressive impulses in a partnership with a man who is partially dependent on her and who is constantly maneuvering himself into situations that seem to justify her punishing him. Polly's husband finds in his wife a partial outlet for his submissive and passive impulses: someone to scold him when he is bad, to think and plan for him when he is puzzled, to extricate him from his scrapes and, most important of all, to worry about him. The relationship is in many ways similar to that of a mother—a scolding but indulgent mother—and her very small boy.

Children Suffer

Under favorable circumstances, if there is adequate income and good enough social standing to avert scandal, these marriages last for years. The children are the ones who suffer the most emotional damage. Polly is too preoccupied to really know her children. She finds no pleasure in giving them the physical care through which mothers build relationships with their children when they are small, and therefore usually turns this responsibility over to someone else. She finds older children and adolescents particularly bothersome, and when they develop emotional problems, as Polly's children frequently do, she gladly turns these over to someone else too. Thus, in counseling we meet Polly as the parent of a teen-ager with whom we are working no less often than as the wife of an alcoholic. The general public is prone to say, "Of course those children are poorly adjusted. What else can you expect? Their father is an alcoholic! It is necessary to point out that the children's problems can only partly be explained in this way.

Counseling with Polly is always directed toward helping her to reduce her controls and achieve satisfaction from womanly and motherly roles. Initially she tries for the same competitive, bullying relationship with the counselor as with everyone else. It is the only kind she knows. Life to her is one long contest, and she must win.

MENTAL HEALTH NOTES

Many people, when they hear the term mental **health** think first of mental **illness.** But mental health is far more than merely the absence of mental illness.

Mental health is something all of us want for ourselves, whether we know it by name or not. When we speak of happiness, or peace of mind, or enjoyment, or satisfaction, we are usually talking about mental health.

Mental health has to do with everybody's everyday life. It means the overall way that people get along—in their families, at school, on the job, at play, with their associates, in their communities. It has to do with the way that each person harmonizes his desires, ambition, abilities, ideals, feelings and his conscience in order to meet the demands of life as he has to face it. It has to do with:

1 **how you feel about yourself**

2 **how you feel about other people**

3 **how you are able to meet the demands of life**

There is no line that neatly divides the mentally healthy from the unhealthy. There are many different degrees of mental health. No one characteristic by itself can be taken as evidence of good mental health, nor the lack of any one as evidence of mental illness. And nobody has all the traits of good mental health all the time.

One way of describing mental health is to describe mentally healthy people. Just **knowing** what mental health is doesn't mean you can go out and **be** mentally healthy, but knowing **can** help you to think straight about it.

Knowing ourselves helps us to live better with others.

HOW TO

When we face our problems with

SEVERAL years ago The MacMillan Company published a book entitled, MANAGING YOUR MIND, by S. H. Kraines, M.D., Assistant Professor of Psychiatry at The University of Illinois Medical School, and E. S. Thetford. It is one of the most readable and enlightening aids toward understanding oneself and living happily in this complex world that your editors have yet come across. It will be reviewed in an early issue of INVENTORY.

In the meantime, however, we are unable to resist printing a short excerpt from this interesting book, because it offers the alcoholic (and other people who worry without taking constructive action) a reasonable basis for relieving the inevitable tension arising from worry.

Worry Versus Reason

"What are you going to do about those problems which you can and must solve? The problems will arise, and you can do one of two things: bring to bear your best 'reasoned out' solution or you can worry, thereby achieving nothing save tension symptoms in your body and perpetual unhappiness in your spirit.

"The universal inclination to worry arises out of the fact that simultaneously we have bodies geared for **actively** meeting danger and the cortical ability to delay our responses in order to choose the best one. Worry arises when one simply delays but does not choose and follow his choice.

"Tension produced by the presence of the problem **must** be released. But worry, far from releasing, further augments tension by keeping the irritation constantly in operation. Reason can help because it offers a plan of activity which if followed will more or less (the degree being determined by the wisdom of the

FACE YOUR WORRIES

reason they can be solved without excessive worry and anxiety.

judgment) adequately solve the problem, and which gives . . . an opportunity to expend its mobilized energy.

"Your best reason will not be perfect, since everyone is limited in experience and ability to foresee; but it is the best you can do.

"The following tabulation will indicate the basic differences between worry and reason.

WORRY VERSUS REASON

WORRY	REASON
1. The emotional tone accompanying worry is fear, disturbance, unrest.	1. The emotional tone accompanying reason is calmness.
2. The problem is vague, ill-defined, and usually confused with other sources of emotional disturbance.	2. The problem is sharply defined and, for the time being at least, excludes all other concerns.
3. Emphasis is placed and concentrated upon the worst possibilities.	3. All possibilities, good and bad, are listed and scrutinized objectively.
4. The worst possibilities are accepted as actualities and reacted to as though they had already occurred.	4. The possible solutions are listed in the order of both their probability and their desirability.
5. No conclusions are reached; no plan of action is decided upon.	5. The best solution possible having been decided upon, a plan of action is formulated.
6. The topic of concern remains constantly in awareness, being ever elaborated and enlarged upon.	6. By a conscious effort of will the problem-solver directs his energies toward following out his plan, occupies his attention with other interests, and otherwise dismisses the subject.
7. The problem is not solved; tension symptoms arise or are aggravated; unhappiness results.	7. The problem is solved; tension is released; emotional stabiilty is maintained."

Books of Interest

PSYCHIATRY FOR THE CURIOUS

By George H. Preston, M.D.
Rinehart and Company, Inc.
New York, N. Y., 147 pages
$2.50

PICTURE a man with a pain in his leg hobbling along on wooden crutches. Then think of a man with emotional pain stumbling through life on an alcohol crutch.

Dr. Preston's analogy is not original of course. But it serves to illustrate the motivation the alcoholic has for his dependency upon alcohol.

The man with the physical injury uses a wooden crutch to ease a bodily pain. The man with the emotional injury employs an anesthetic to ease mental pain.

The mental pain of the alcoholic centers around his extreme sensitivity. Without alcohol, he is frequently overly self-conscious and insecure. He is racked by self-criticism and sees himself decidedly inferior to his associates. He has never been permitted to learn self-confidence and self-reliance, and therefore self-approval.

Alcohol helps drown this self-criticism. It enables the alcoholic to meet others more comfortably. It lends the self-confidence, the self-approval he so badly needs.

You don't, Dr. Preston writes, kick the crutches out from under the man with a broken leg and tell him to go on and walk. Nor should we sweep alcohol away from the man with emotional disorder and expect him to drag painfully along without some other form of support—in the nature of insight into his basic problems and treatment for them.

When a man has a broken leg, you don't try to "cure" his wooden crutches, the author goes on. You treat the damaged limb, not the crutches. The same point of view is essential in regard to alcoholism. The focal point of therapy must be the underlying personality disorder, not the excessive drinking. The latter is only the crutch for and symptom of the fundamental problem.

Many physicians, ministers and other interested professionals, as well as inquiring laymen, will benefit from Dr. Preston's discussion of alcoholism in this down-to-earth, lucid little book.

As the title implies, alcoholism is only one of the subjects discussed. The bulk of the book is given over to a vivid discussion of various types of emotional illness, human needs as related to these illnesses, and a pithy elucidation of the nature of psychiatric treatment.

Means Of Adjustment

Dr. Preston advises that we must view human behavior on a continuum. He emphasizes that we all are pretty much alike. Some simply manifest certain personality characteristics in greater degree than do others. We all use the same mechanisms of adjustment, but the emotionally ill use them "more rigidly and less appropriately." Hence emotional illness is a matter of difference in degree, not kind.

Within this framework Dr. Preston explains his principal thesis. Our basic need, he holds, is to keep from being hurt (security). To fill this need we engage in many defenses: withdrawal, overactivity, projection, physical illness, the use of alcohol and drugs. Each of these behavioral defenses is discussed at length in a non-technical easily understood way.

This quaintly illustrated and humanly written book is a companion volume to the author's THE SUBSTANCE OF MENTAL HEALTH. Together they give a warm, understanding picture of human behavior not found elsewhere.

—Norbert L. Kelly, Ph.D.
Education Director

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
415 Halifax St.
RALEIGH, N. C.

Phone: 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.

Phone: 3-8343
Monday through Friday

Mental Hygiene Clinic
210 N. Greene St.
GREENSBORO, N. C

Phone: 3-9426
Also at HIGH POINT
Phone: 8929
Monday through Friday

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.

Phone: 3-5441 & 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.

Phone: 3-2471, Ext. 29
Monday through Friday

Graylyn Hospital
WINSTON-SALEM, N. C.

Phone: 3-7391

FRIDAY ONLY. This is purely a Clinic for alcoholics and their families. Out - patient mental hygiene clinic is located at Baptist Hospital, Winston-Salem.

Toward helping patients to re-establish satisfactory social relations all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly journal using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The Butner Brochure—illustrated 36-page book on North Carolina's program of treating alcoholism as an emotional sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

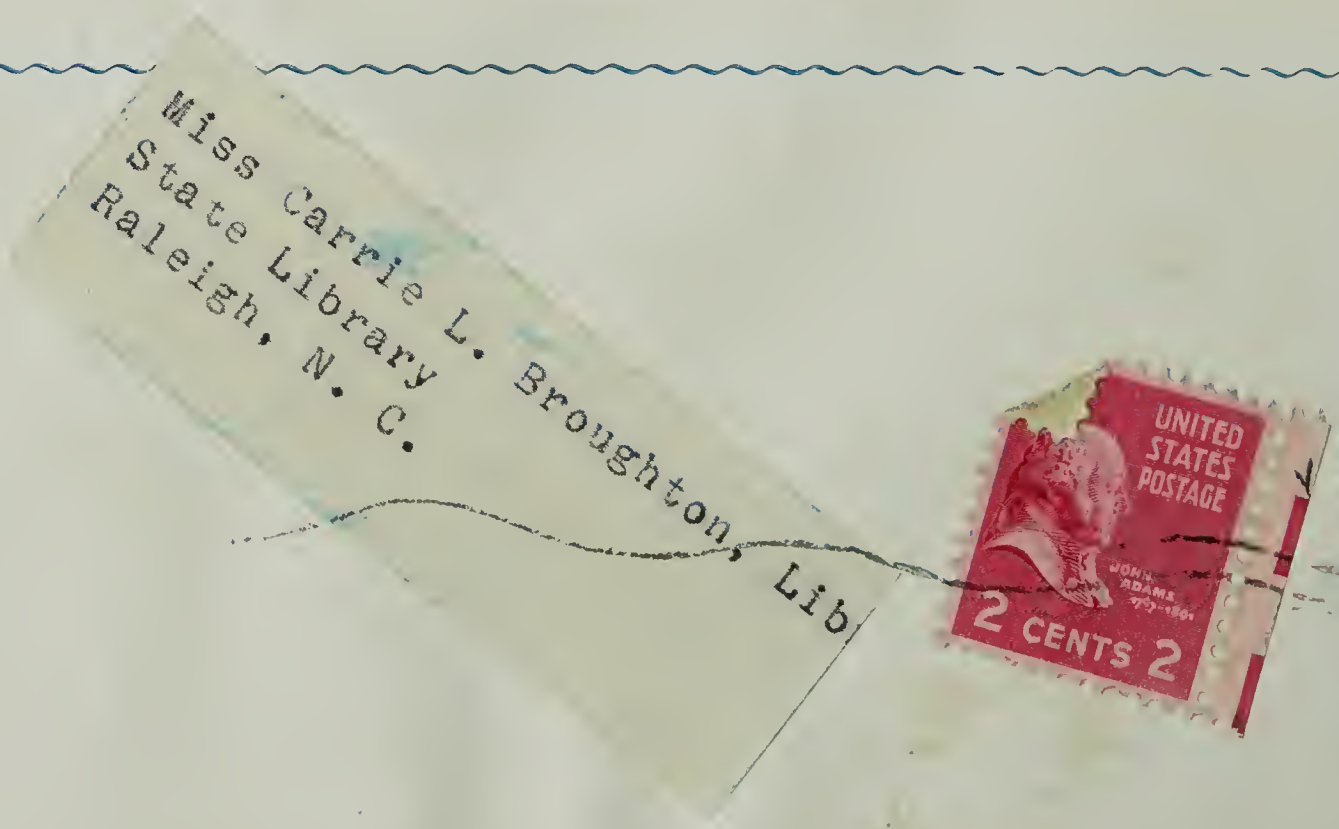
Library Kits—kits containing books and pamphlets on alcoholism. Available to libraries from N. C. Library Commission, State Library, Raleigh.

Book Loan Service—kit of reference works on alcohol and alcoholism, for high schools. Order from Education Director, Box 9118, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
Box 9118
Raleigh, N. C.



Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

JULY, 1954

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

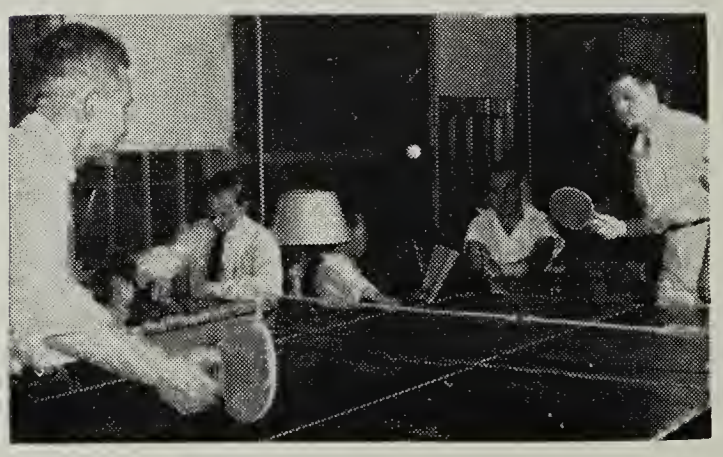
EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $72 for 28 days' stay.



Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, a social worker, a recreation director, an occupational therapist, and ten attendants.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.
2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history compiled by the patient's family physician are necessary.
3. A fee of $72, in cash or certified check, must be paid upon admission.
4. The signing, on admission, of a letter-statement, which requests voluntary admission.

Admitting Hours

8 A.M. to 11 A.M. Monday through Saturday
1 P.M. to 3 P.M. Monday through Friday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM
OF THE
NORTH CAROLINA HOSPITALS BOARD OF CONTROL

S. K. PROCTOR
Executive Director

NORBERT L. KELLY, Ph.D.
Educational Director

LORANT FORIZS, M.D.
Clinical Director

INVENTORY

VOLUME IV — NUMBER 2

JULY, 1954

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices, 429 Agriculture Building, P. O. Box 9118, Raleigh, North Carolina.

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This journal is printed as a public information service, currently serving 15,800 readers. Persons desiring a place on the free mailing list must send in a written request. This journal will not be sent to persons other than other requesting it.

Write: INVENTORY, Box 9118, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

He's From Missouri

This letter is being written after having studied a copy of a booklet sent me on request, presenting the first annual summer studies on "Facts About Alcohol in North Carolina." At this time, this letter is being written about some of the many services you list in your booklet, such as INVENTORY, your Butner Brochure, Cornerstones, Anyone You Know, etc. I wondered if it were possible for me to receive copies of these various services so that I might, perhaps, use them in furthering our work here in the State of Missouri and especially in St. Louis. I also, at this time, would like to commend the splendid program which you have set up for education on alcoholism and with regard to alcoholic rehabilitation in your State. It is my hope that we in Missouri will in the not too distant future, have as fine a program.

Dr. Joseph B. Kendis, M. D.
Saint Louis, Missouri

Proud of the Program

I look forward to each issue of INVENTORY and find many things of interest in it. The Program of Alcoholic Rehabilitation in our State is something I am very proud of and hope we will be able to expand it in our western area.

Margery J. Lord, M.D.
City Health Officer
Asheville, N. C.

Appreciates Interest

Received your letter and appreciate your interest in my welfare since leaving Butner. I feel that my stay at Butner was most beneficial; for the first time I felt that someone was trying to help me understand myself and help me cope with my problems. I really enjoyed those 28 days and found both doctors and attendants most sympathetic and kind.

A former Butner patient

Thanks From Charlotte

Let me again say how helpful we have found INVENTORY here in Charlotte, and I do appreciate it very much.

Mrs. Louis G. Rogers, President
Charlotte Mental Hygiene Society
Charlotte, North Carolina

Sobriety Is Obtainable

If a man goes to Butner with one objective in mind, and that objective is sobriety, he can attain it. I was sincere in my efforts to learn something about myself and find some kind of foundation on which to stand. Being at the ARC helped me considerably in this regard. I am now sober and am very grateful to Butner and to AA.

Mr. H. G.
Greensboro, N. C.

Palmetto's Read Inventory

I am in receipt of the literature which you so graciously sent us. I will distribute this material at our special AA meeting tomorrow. We have invited some twenty outside groups to be our guests and to help us form a sponsorship program for our group.

Many of our visitors speak to me about your fine publication, INVENTORY, which we have the pleasure of reading ourselves. We are very grateful to you and your fine State for sending us your literature for our AA group.

Bob S., Secretary
Palmetto AA Group
Columbia, S. C.

Program Pointers

By S. K. Proctor
EXECUTIVE DIRECTOR

WE are very happy to report that our Summer Studies on Facts About Alcohol, conducted primarily for teachers, have received an exceptional response. The course at East Carolina College was again this year the largest class on the campus, having an enrollment of 60. This is an increase of seven over last summer. Alcohol studies at A. & T. College had an enrollment of 26, which was most encouraging. We received some extremely favorable comment from the Greenville and Greensboro groups regarding the nature and content of the classes there, and indicating a new appreciation and understanding of alcoholism. At the time of this writing, the course at Appalachian State Teachers College in Boone is in progress, with 18 teachers enrolled. Inasmuch as this is the first year that summer studies on alcohol have been offered at either A. & T. or Appalachian State, we hope that next year's courses will see an even larger enrollment at both schools.

Public Thanks

I wish to thank publicly all those people who served as guest instructors and lecturers in our summer sessions. It was necessary for them to give much of their time and effort in preparation and in the actual class sessions. Congratulations to them for a job well done!

We have recently purchased a number of books to be furnished the libraries of 30 of North Carolina's 34 senior colleges. These book kits, which will be mailed in the near future, will contain many of the best and most reliable volumes on alcohol, alcoholism, and mental hygiene. We believe that college students will find them stimulating and informative.

We feel that your NCARP has been distinctly honored by having three of its staff members invited to participate in the program at the Yale Summer School of Alcohol Studies this year. Dr. Norbert Kelly, Miss Roberta Lytle, and I have received summer school faculty invitations, and we are taking part of our vacation period in order to be there and make our contribution.

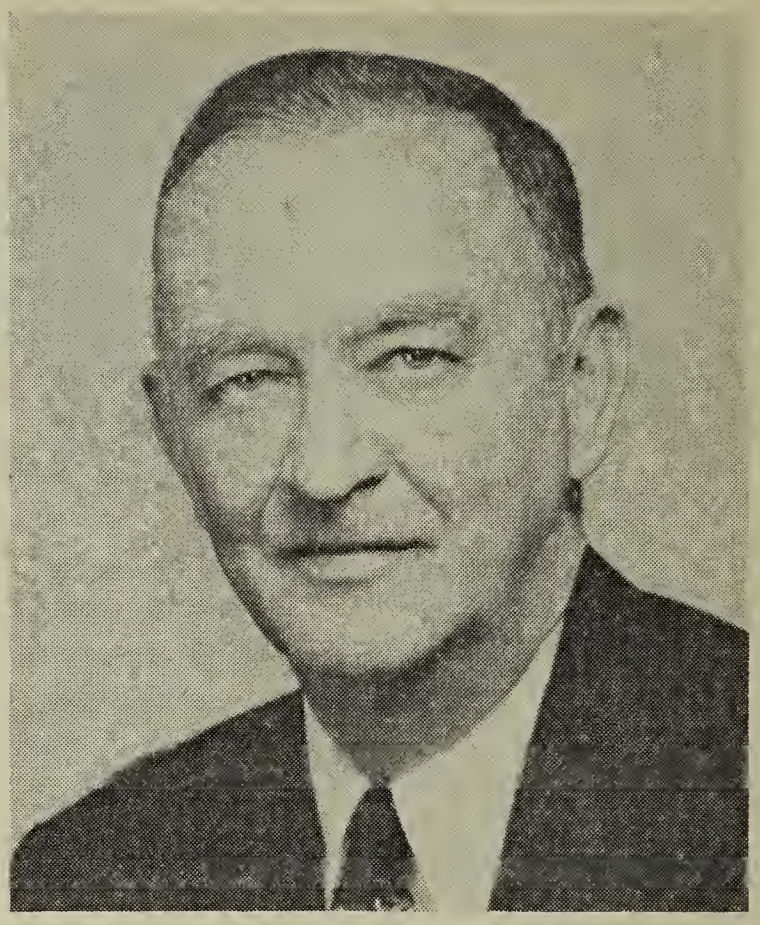
New Clinic Added

For some time, now, we have been negotiating with the out-patient service of the Department of Psychiatry at the N. C. Memorial Hospital on an arrangement for out-patient services to alcoholics and their families. Our efforts toward this end have been successfully concluded. The addition of the out-patient psychiatric service at Chapel Hill to the growing list of resources available to problem drinkers desiring help greatly strengthens our overall program of services.

Looking to the coming session of the Legislature, I don't believe that it is too early to urge you to inform yourselves about the mental health needs of our State. The N. C. Department of Health is asking the coming Legislature for $190,000 per year for an expanded Mental Health Program in North Carolina. Should this amount be appropriated, we can hope to see the present six Mental Hygiene Clinics expanded to Mental Hygiene Centers, in order to serve larger areas and more people. Also included in the plans would be the or-

(Continued on page 18)

Personality Sketches



JOHN W. UMSTEAD, JR.

Chairman,
N. C. Hospitals Board of Control

SUCCESSFUL insurance executive, legislator, public servant—John Umstead personifies the Man of Action. The Umstead brand of action will leave its mark on the life of North Carolina, for he has been responsible for some of the most beneficial legislation enacted in the State for 20 years. Umstead-sponsored measures have brought the dawn of a new hope and optimism among our emotionally ill citizens and their families.

Mr. Umstead's public career began without fanfare back in 1931 when he was elected to the State Senate from the 16th district. Since then, he has never been defeated in a race for the legislature, though there have been several years that the press of business did not permit him to run. He is now firmly established as Representative from Orange County. Since the 1943 General Assembly session, when he directed the fight to establish the 9-month school term, Umstead's influence has been a power to be reckoned with on the State scene.

After leading the school fight, he came to the next law-making session to find himself appointed chairman of a committee to investigate conditions in the State's mental institutions. Mr. Umstead's face clouds when he recalls how this investigation brought home to him the "almost criminal neglect" of our State's mentally ill people, including those suffering from the emotional illness of alcoholism.

It disturbed Umstead that during the investigation he never heard the words, "treatment," "cure," or "rehabilitation" used. The biggest concern of the mental hospitals at that time seemed to be in providing space for the confinement of emotionally ill patients being held in county jails over the State.

Board Reorganized

As a result of his Committee's report to the legislature the Hospitals Board of Control was reorganized, and the "gentleman from Orange" was appointed a member of that body. He has since been elevated to its chairmanship.

The biggest undertaking to grow out of the Umstead-sponsored reorganization plan was the acquisition by the State of Camp Butner—a 14,000-acre former Army camp site owned by the Federal Government. To Umstead was committed the task of acquiring the property from the War Assets Administration, and

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VOL. IV, No. 2 **INVENTORY** JULY, 1954

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

Educational films increase understanding of alcoholism and promote better mental health practices.

FILMS have a special appeal for our fast-moving, scientific age. Sometimes they can be a powerful force for constructive action, as when they are used to inform us of what to do in case of enemy attack. In other instances they can produce a bad effect, as for example, when they give foreign cinema goers the impression that all Americans are champagne-drinking capitalists. But whether for good or bad, a well-produced movie will have its effect on an audience. It will evoke some kind of reaction from its viewers and create a lasting impression on the minds of those who see it.

Whether films are used for propaganda, entertainment, instruction, or education, they are a powerful, popular method of getting across all sorts of information—from the simplest to the most technical and abstract. Seeing a movie adds to our understanding of a subject by bringing another one of our five senses into the learning process. To *see* for ourselves what we are talking about makes our learning more complete. Indeed, the eye can often teach that which no words can convey.

Yes, *seeing is believing.* That is why educational films are used so effectively to teach good emotional health practices, and to increase public understanding of emotional illness—including alcoholism. The North Carolina Alcoholic Rehabilitation Program, recognizing the appeal of films in education, makes extensive use of visual aids in its program of alcoholism treatment, education and prevention.

At the NCARP treatment center for alcoholics, carefully selected and professionally produced films on personality development play a major role in helping patients there to understand themselves

and their emotional illness. Through the magic of the moving picture, which can flash from the present to the past and back again in the twinkling of an eye, patients see how the road to emotional maturity can be blocked by childhood experiences. Through the experience of *seeing* how retarded emotional development makes the film character into an uncomfortable, unhappy adult, the alcoholic patient is able to better see and understand himself. He begins to grasp how he, too, became an uncomfortable and unhappy adult having to rely on alcohol for comfort and relief.

Before Group Therapy

Films on personality development are shown to patients at the ARP treatment center immediately before each group therapy session. The things patients learn from the movies, plus those of their own experiences which the film has brought back to memory, provide the meat for the group discussion that follows.

Patients view another type of instructional movie at the Alcoholic Rehabilitation Center. This type presents graphic accounts of the progress of alcoholism—how it affects the problem drinker, his family, his friends, etc. Films such as, "I Am An Alcoholic," and "Problem Drinkers" are included in this grouping. These films carry a forceful message—alcoholism is an illness, the alcoholic is a sick person, his illness can be arrested, treatment is available, AA may help. It is not the purpose of these films to depict the underlying emotional causes of alcoholism. Nevertheless, their pictorial message can be important to the problem drinker. The alcoholic may have so much regret over his past conduct that he has never accepted the fact that he is a sick person, or that his illness can be treated and arrested. Seeing films on alcoholism may help him to clear this first hurdle, and motivate him to enter treatment in a hopeful, receptive frame of mind.

Besides being used in the treatment of problem drinkers, visual aids pack a solid punch in helping advance the NCARP's program of prevention and public education. A movie projector and several reels of film are part and parcel of the baggage of members of the ARP speakers service, as they travel over the State addressing hundreds of civic, religious, and education groups every year. Experience has been that talks about alcoholism always stimulate more interest from the audience when an appropriate film is tied in for emphasis.

Several years ago, the NCARP set aside funds in its budget for the purchase of a number of films on alcoholism and emotional health. After their purchase, they were placed in the Visual Aids Library of the State Board of Health. Here, they may be borrowed for showing to interested persons and groups over the State.

Wide Circulation

Since their availability has become known, ARP-sponsored films have enjoyed wide circulation. PTA groups, civic clubs, church groups, teachers' organizations, school hygiene classes—these are representative of the varied groups using the film lending service of the Health Department's Visual Aids Library to increase their knowledge of alcoholism and emotional illness.

Many of the same films shown to patients in treatment at the N. C. Alcoholic Rehabilitation Center are also circulated to the public. A person approaching any of the movies with an open mind can get something useful and helpful from them. For example, an alcoholic patient

(Continued on page 20)

GIVE THEM THE FACTS

IT is particularly important that high school students be exposed to facts, not prejudices, as they formulate opinions concerning personal behavior with regard to . . . drinking. Direct prohibition is not education and it contains the seeds of failure.

—Charles C. Wilson, M.D. in *Health Education,*

Why People Drink . . .

BY HORACE CHAMPION

EDITOR

Behind all drinking lies the desire to feel more comfortable. The extent of one's discomfort and unhappiness determines his susceptibility to alcoholism.

BEER, wine and whiskey are made by different methods and they do not taste at all alike, but each contains the common ingredient which is responsible for their popularity—alcohol.

A person may like the taste of beer or wine or whiskey, but it is extremely doubtful that he would prefer an alcoholic beverage to a non-alcoholic beverage on the basis of taste alone. People drink alcoholic beverages primarily for their effect on feelings or attitudes.

The effect which a person attempts to achieve by drinking alcohol is, broadly speaking, *a state of feeling more comfortable.* This is true of the young man who takes a drink or two before going to a dance; of the person who has a cocktail before dinner or a shot of whiskey before going to bed. It is true of the person who fortifies himself with a few drinks before attending a party, or before making love. It is true even in the case of the person who does not like the taste or the sedative effect of alcohol but who drinks with the crowd "because the others do." He feels that he must drink in order to belong to the group, in order to be more comfortable in the company of his friends.

It is especially true of people who habitually drink to excess and people who become addicted to alcohol. These people are excessively and chronically uncomfortable in their feelings about themselves or in their relationships with other people or in their attitudes toward life's problems.

Of course, all of us are uncomfortable and unhappy at times; it's part and parcel of the process of living. We all have our frustrations and anxieties, our disappointments and worries. But most of us seem able to face our problems without becoming bowled over by them, without letting our emotions block all understanding and constructive action toward solving our problems—and without leaning on the crutch of alcohol whenever things go wrong.

Most people are reasonably comfortable and happy *most of the time.* They realize that life really is a bed of roses, complete with thorns; but their healthy perspective toward life as a whole en-

(Continued on page 23)

A HISTORY OF AMERICAN DRINKING CUSTOMS

Whether we like to admit it or not, a study of history shows that the use and misuse of beverage alcohol has been widespread in America ever since the first permanent settlement at Jamestown in 1607.

BY NORBERT L. KELLY, Ph.D.

EDUCATIONAL DIRECTOR, NCARP

Excerpted from a larger study of world drinking customs

SOME of us are fond of talking wistfully about the "good old days," when our ancestors lived in a supposed state of perfect peace, harmony, and sobriety. Oldsters are particularly wont to compare life in the idyllic past with what they consider to be the immoral ways of the present, and on the basis of this comparison to predict all sorts of dire ends for "this younger generation." This tendency to condemn the present and to idealize the past is particularly true in considering our present-day American reputation as a nation of hard drinkers.

Upon taking a closer look at our American ancestors, we find that when we think of them as having lived completely contented, sober lives we are guilty of romanticizing what was often in reality a rugged, lonely, discouraging existence. That alcohol was used freely in an attempt to break the monotony and to relieve the toil of life in a new land is a proven historical fact. A study of our early American history shows that our predecessors on this continent were, indeed, hard drinkers, and that beverage alcohol has played an important role in our social customs ever since the first European explorer set foot on this soil.

In 1607, the first permanent English settlement in America was founded in Virginia. With this first colonization, European drinking customs arrived in our land to stay permanently.

Drinking was widespread in colonial Virginia and there is evidence of much inebriety. In fact, the first law against drunkenness was enacted just twelve years after the planting of the colony. In 1619, the first general assembly de-

creed that ". . . any person found drunk for the first time was to be reproved privately by the minister; the second time publicly; the third time to 'lye in halter' twelve hours, and pay a fine. For every succeeding offense punishment was left to the discretion of the governor and his council." In the same year, however, the assembly passed an act encouraging the production of wines and ardent spirits in the colony. Thus it was not the custom of drinking, but that of drinking to excess which was frowned upon in colonial Virginia.

Hard drinking continued in Virginia throughout colonial times, in spite of frequent attempts by the assembly to legislate against excesses. Even the Virginia clergy were not immune to the drinking customs of this era.

In neighboring Maryland, a wide variety of drinks was available. Included in a drinking catalogue of the day would be rum, sherry, Rhenish wines, Canary, Madeira, cider, claret, strong ale, French brandy and wine.

Sessions of county courts in Maryland were scenes of heavy drinking, as they were also in many of the early colonies. Marriages, house parties, dances, friendly gatherings, in both Maryland and Virginia were judged incomplete unless strong drinks were served. Even funerals were not exempt from drunkenness.

To the North, in the Massachusetts Bay colony, the Puritan fathers were a more sober group in the early years. Yet the custom of drinking was an accepted art in the everyday life of the Puritans. The ship Arabella which brought Governor Winthrop to Massa-

(Continued on page 20)

HOW TO HELP AN

IN recent years, science has come forth with a great deal of new knowledge about the complex illness of alcoholism and the inevitable emotional chaos that both creates and sustains problem drinking. The acquiring of this new knowledge by the public is a necessary step toward helping unfortunate fellow citizens to recover from the insidious illness of alcoholism. It is obvious that we cannot help to solve a problem unless we understand the nature of the problem.

You might well ask: "How can I use this knowledge toward helping my husband, wife, or friend to recover?" First, ask yourself if you still feel as resentful or critical of that person's drinking as you did. Have you gained the emotional strength necessary to tolerate the situation for awhile longer, knowing full well that you cannot help him to recover overnight? If your resentment has decreased considerably and you can face the situation without becoming panic stricken, you have achieved understanding and can begin to help him. Just as an alcoholic can sense resentment so can he sense an understanding attitude.

Think for a moment about your past attitudes—especially if you are the wife or husband of an alcoholic—and consider how futile they were in improving the situation. Did you 'rake him over the coals' when he drank, reminding him of his neglect of the family, his failures to accept responsibility, his weakness of character, etc.? What did it accomplish?

Silent Scorn

Did you develop a 'holier-than-thou' attitude, making him feel the deep barbs of silent scorn? Divorcing him emotionally is often worse than divorcing him legally. It leaves no way out for either of you.

Or did you become over-emotional,

If you would help an alcoholic recover, take inventory of your own attitudes to see that they are healthy and helpful rather than resentful and critical.

BY HORACE CHAMPION

EDITOR

ALCOHOLIC

crying, "If you loved me . . ."? He may love you very much, but this appeal only creates for him additional guilt feelings and for you a feeling of not being loved. It is an unrealistic approach to the compulsive drinker because compulsive drinking cannot be controlled by will power alone.

Carry Out Threats

What about your threats? Did you threaten to leave him if he did not stop drinking? Did you carry out your threat? There may be times, for your safety or for the children's sake, that you should leave. No one can be expected to bear continued abuse with equanimity. But if you threaten to leave him, carry out the threat—leave him! Try not to be emotional about it. After you threaten to leave a few times and fail to leave he will not believe you.

In your disgust did you pour his whiskey down the drain, only to find that either he had another bottle well hidden or would find some way of obtaining another? All this accomplished was to push him into a state of rage and resulting determination to drink more no matter what the cost.

Did you wallow in self-pity at being married to an alcoholic? Did you bear your heavy burden in silence, withdrawing from all outside activity, shutting yourself and family off from the rest of the world? Or did you secretly enjoy the words of sympathy you got from your friends and neighbors at being married to a person who abuses and neglects his family? In either case neither your situation nor the problem drinker's was improved, was it?

Self-Pity Unhealthy

All forms of self-pity and self-punishment are unhealthy states because they block proper perspective of the problem as well as constructive action toward solving it. If you are to help someone to recover from alcoholism you must develop healthy attitudes that will allow you to face the situation objectively and with reason. Knowing what the unhealthy attitudes and approaches are will help you to avoid them as a basis for developing new, helpful attitudes. It will also make you a happier person.

Members of Alcoholics Anonymous take personal inventories of their shortcomings and attitudes and they try to correct them day by day. Many of their wives do this also and report amazing improvement in their relationship with each other and with the children. If your husband or wife or friend has not yet expressed a sincere desire for treatment you should not let this destroy your own happiness or peace of mind. Take a sheet of paper—better take several sheets—and write at the top of one, ASSETS. Write at the top of another, LIABILITIES. Be honest with yourself; you needn't show it to anyone else. Start with some of the emotional liabilities listed above. Do you have any of these? List them. We all have them, so don't be bashful. Fill in the emotional assets, too. You will begin to see yourself in a new

(Continued on page 27)

Jim, here, is a sick man. Drinking is disrupting his life but he is powerless to control it, because of alcohol's very special effects for him.

12 STEPS TO SOBRIETY

ALCOHOLICS ANONYMOUS

IN the present-day treatment of alcoholism, Alcoholics Anonymous plays an outstanding role both as a method in itself and as an ally to the methods practiced by the medical and other professions.

The unique feature of AA is that it is composed of alcoholics who have recovered or are on the road to recovery through AA methods. Anyone who sincerely wants to lick his alcoholism can join the fellowship.

The alcoholic receives a tremendous boost in his desire to recover and to give up alcohol as he comes into contact with and gains an understanding of other men and women who have already accomplished what *he* wants to do.

Fighting alcoholism alone is an uphill, almost impossible struggle. AA members give each other mutual support and a feeling of belonging, so that the alcoholic doesn't face the fight alone. This knowledge gives him an added boost toward sobriety.

AA began back in 1935 when two alcoholics, a stockbroker and a physician, met together in Akron, Ohio. They were able to achieve sobriety through mutual support and by applying certain religious principles. They became so enthusiastic over their own success, that they set about to develop a program in which other alcoholics might share. The "Twelve Steps to Recovery," on which the AA fellowship and program are based grew out of the experiences of the stockbroker and the physician as they fought together their battle against alcoholism.

After the appearance of "The Twelve Steps" in 1938, AA began slowly to pick up momentum. In 1939 there were three AA groups in Akron, Cleveland, and New York. The founders wrote a book in

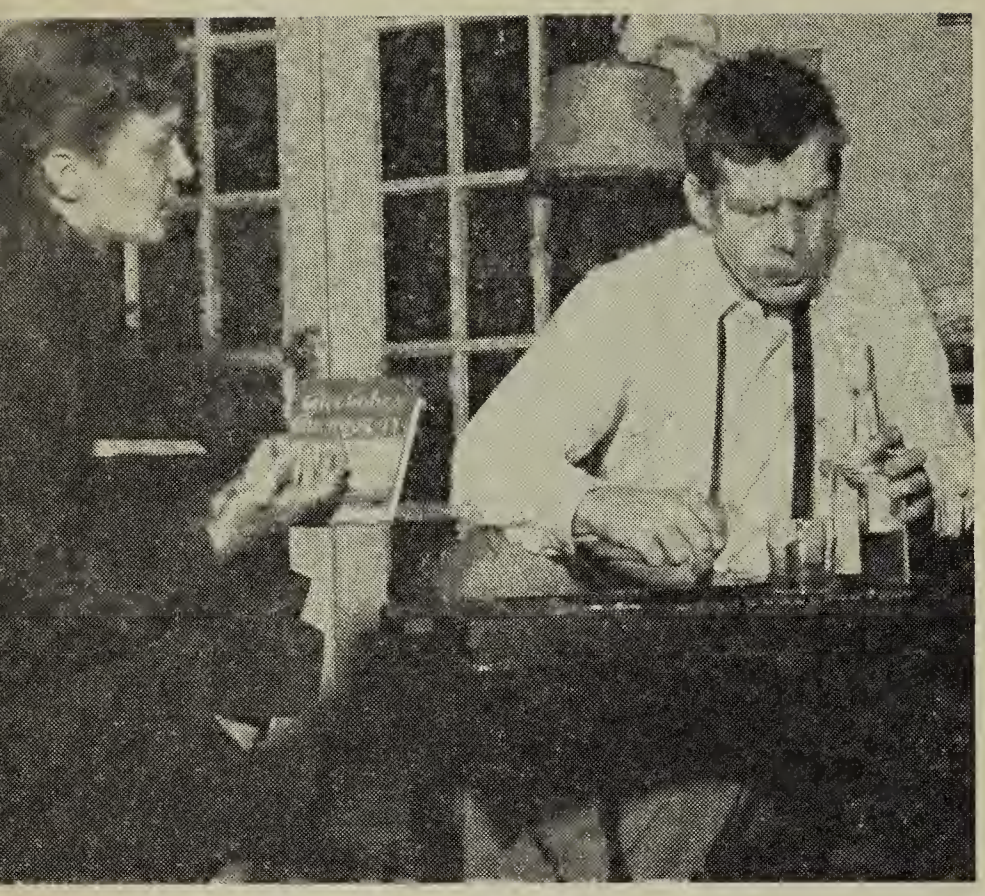
(Continued on page 19)

Photo Story

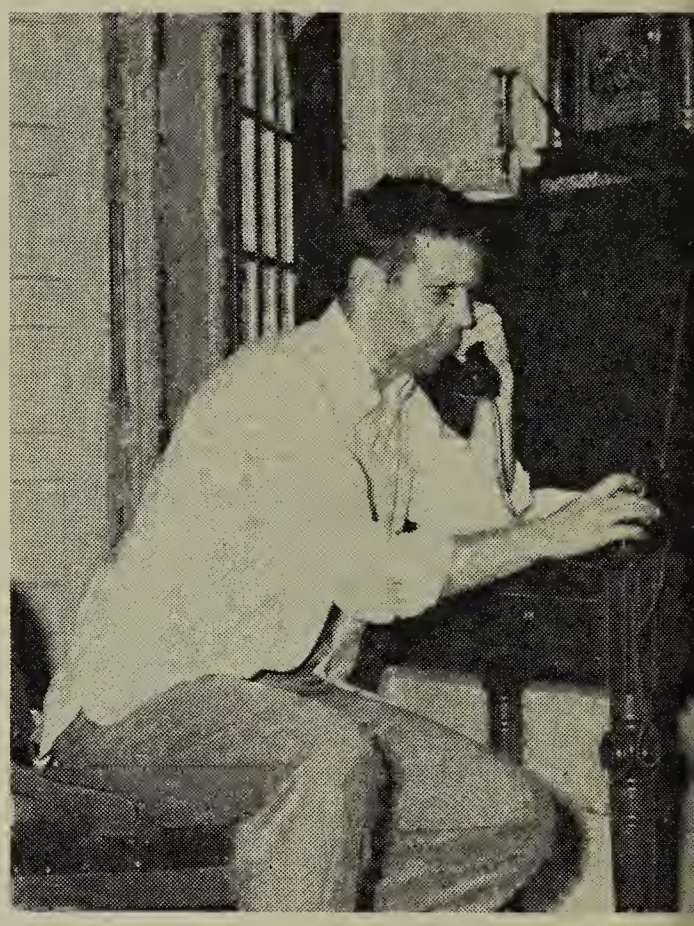
Jim's hangover catches the boss in a bad mood and he is fired. More drinking will soften the blow.

Perplexed by Jim's drinking, his wife seeks aid from their pastor. He suggests Alcoholics Anonymous for Jim, and gives her a copy of the AA book to read.

JULY, 1954



Jim's wife confronts him with the idea of trying AA to lick his drinking problem. But he is not yet ready to admit his need for assistance.



As he is getting over another bender, he realizes his helplessness and dials the AA number to ask their assistance.

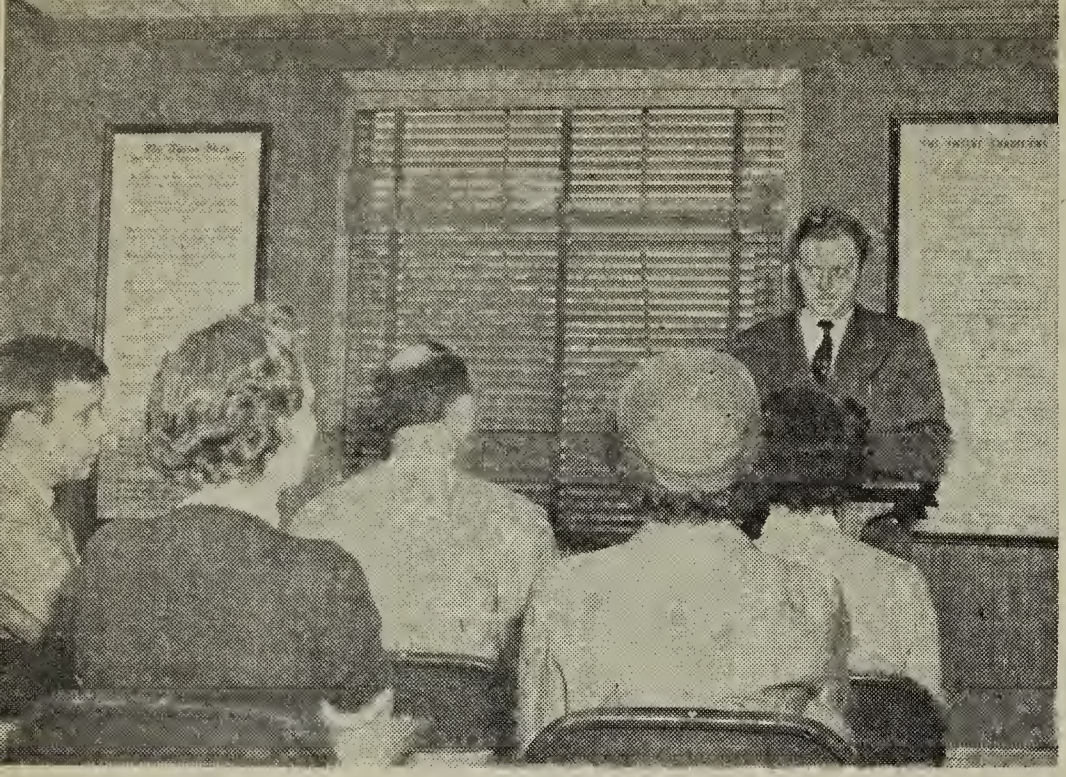
In response to his call, an AA member arrives. An alcoholic himself, he makes Jim feel that he understands and can help.

AA offers no lectures, only concrete aid. Physical treatment and rehabilitation in the local hospital is the first step.

With help, Jim finds it possible to deal with some of life's problems without depending on alcohol.

All pictures posed by dramatic art students from the University of North Carolina. The minister is Dr. H. P. Powell of Edenton Street Methodist Church, Raleigh, N. C.

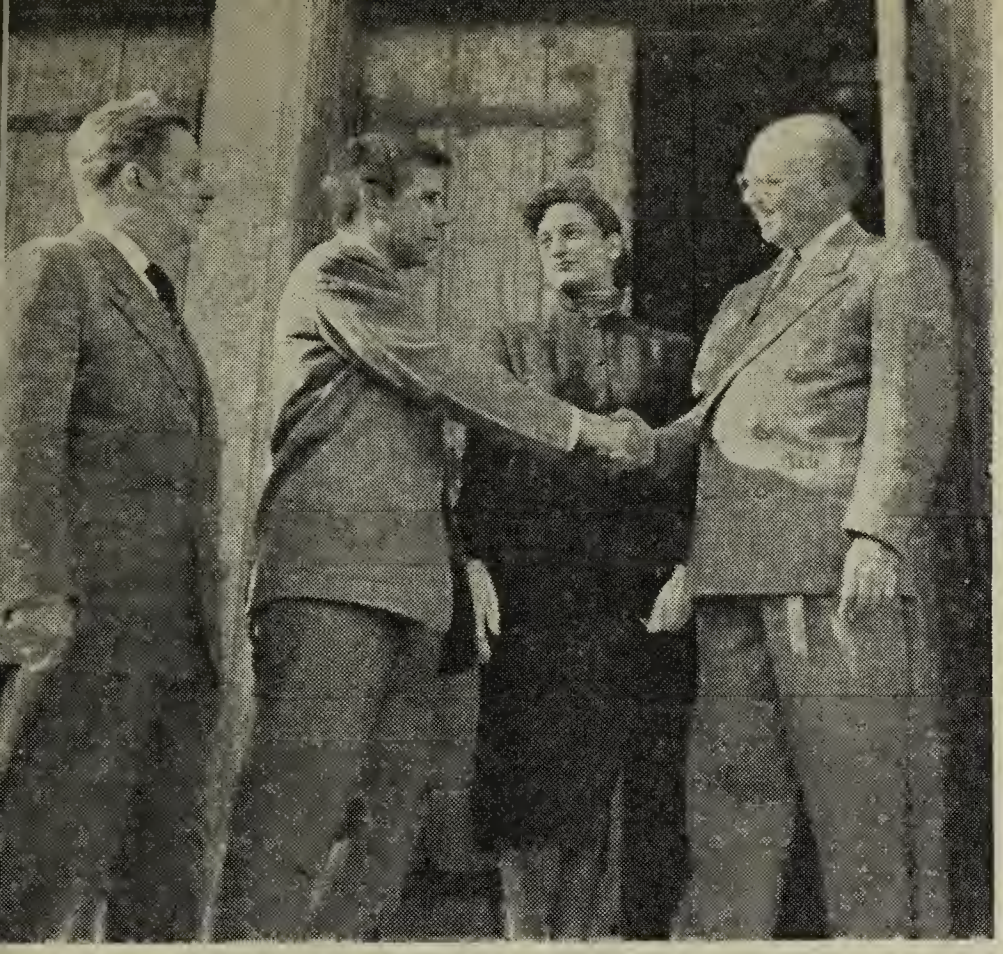
Taken to his first AA meeting, Jim is surprised to find that people can be as happy and relaxed as these are with no stronger drink than coffee.



Jim hears other AA's explain how they put sobriety on a 24-hour basis. "If others can do it," he thinks, " why can't I?"

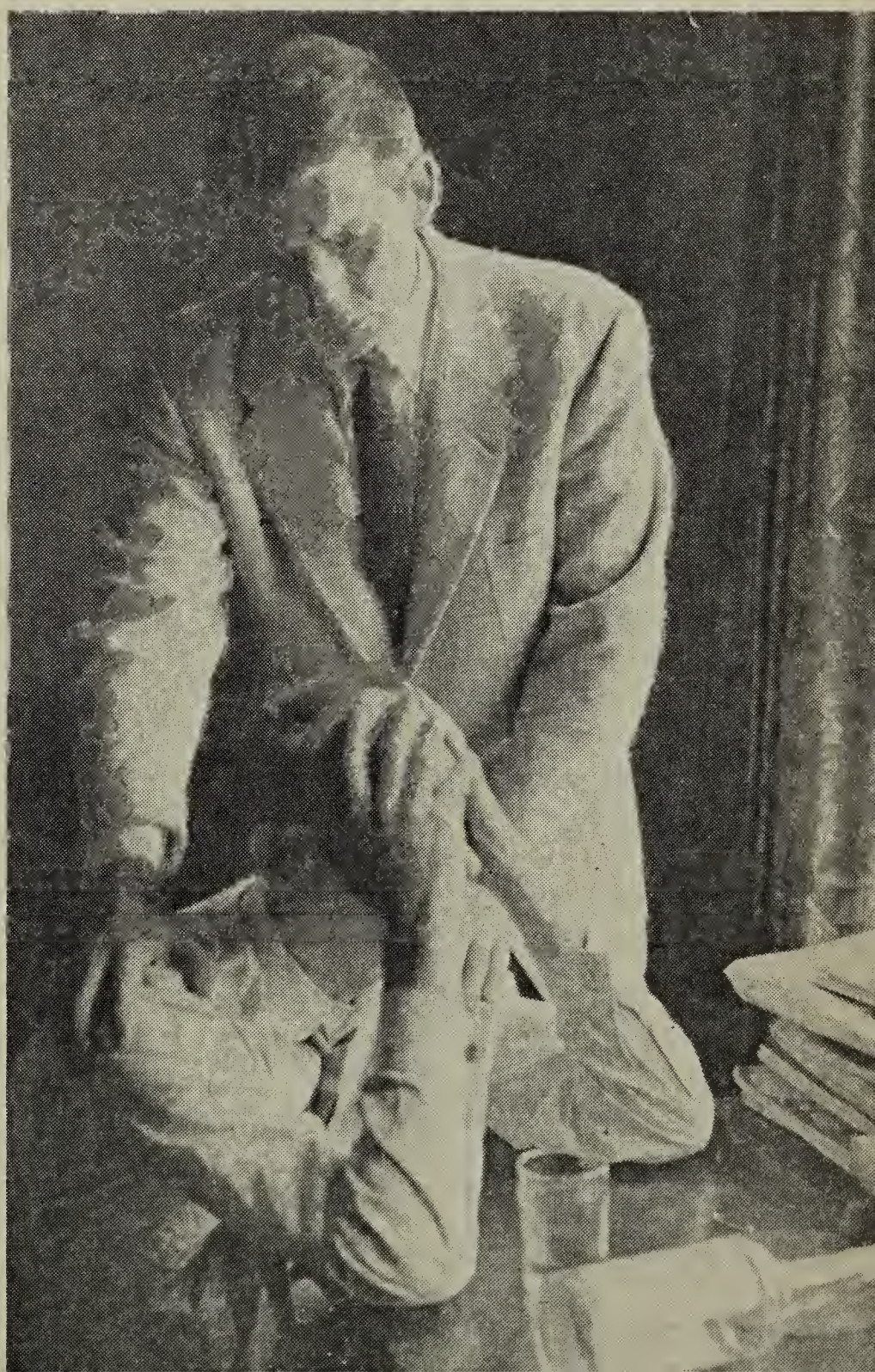
Meantime, his wife is gaining understanding by associating with other alcoholics' wives in the local AA Auxiliary.

His new-found sobriety plus his wife's understanding of her own shortcomings brings new satisfactions and happiness to their everyday relationships.



Recovered and stronger by the knowledge of his illness, he regains his place as a respected member of the community.

Jim's final achievement: the ability to help others. AA's know that when they help other sick alcoholics, they are insuring their own sobriety and happiness.



Program Pointers

(Continued from page 3)

ganization and development of four new Mental Health Centers, to serve areas of the State which do not now have ready access to such facilities.

Existing Mental Hygiene Clinics are a valuable resource to the ARP in its efforts to reduce the incidence of alcoholism among our people. Any increase in the number of clinics or in their services can be looked upon as new resources for this Program and its work. I solicit your support for the movement to expand mental health services.

Personality Sketches

(Continued from page 4)

of laying plans for developing Camp Butner as a mental hospital.

The State Hospital at Butner firmly established, the Orange County legislator came back to the 1949 session to take the floor again in behalf of the State's emotionally ill. Along with two of his legislative colleagues, Clifton Blue of Moore County and Frank Kilpatrick of Pitt, Umstead introduced a bill setting up the North Carolina Alcoholic Rehabilitation Program, with a provision for the establishment of an in-patient treatment center for alcoholics on the Butner site. Umstead recalls with a sparkle in his eye that, "we had our trials and tribulations in getting the bill through." But a resistive customer never discouraged a real insurance man, and with the aid of some skillful maneuvering he was able to "sell" his bill to the legislature.

Umstead's interest in alcoholism and its treatment has never waned. He has recently helped to secure the newly-added facilities at the Alcoholic Rehabilitation Center for the treatment of female problem drinkers. When he says "I am thoroughly sold on the North Carolina Alcoholic Rehabilitation Program," it's obvious that he means what he says.

Serves UNC

Ranking next to his concern for the emotional health of our people, and the educational opportunities of our children, is Umstead's fondness for his alma mater, the University of North Carolina. He serves on the UNC Board of Trustees and is a member of the University's Executive Committee. Besides all these activities, he somehow finds time to be active in church and civic affairs in and around his home town of Chapel Hill.

The man from Orange County is a confirmed worker of cross-word puzzles, even during sessions of the Legislature. It is his way of concentrating and keeping relaxed at the same time. He admits to consuming at least two books of puzzles at each General Assembly. Though appearing to be completely engrossed in puzzle-working, Umstead often amazes his colleagues at his ability to keep up with proceedings and to jump immediately into the debate when anything important comes up—particularly anything affecting mental hospitals, public schools, or the State University.

In view of his past accomplishments, one might expect that John Umstead would be content to settle back and en-

ACCEPTANCE OPENS DOORS

THE crying need of the alcoholic is for acceptance; upon that everything hinges: the resolution of emotional conflicts, the attainment of better insight into the goals of his behavior patterns, the working through of disturbing or perplexing reality matters .

—Claude L. Brown, M.D. in the *Yale Quarterly Journal*

joy some of the hunting and fishing which have for the most part been crowded out of his busy schedule. But in the tradition of the dedicated public servant, he is already looking to the challenge of the future. "Cases of emotional illness must be detected early," he says with conviction. "Today we evaluate effort in the field of mental illness in terms of *treatment* and *rehabilitation,* but we must add another objective—prevention." Mr. Umstead wants to see the day when out-patient psychiatric clinics will be set up in every county in the State, so that every citizen who has symptoms of developing emotional illness can get early treatment. "And we must educate the public," he says firmly, "to accept mental and emotional illness as a curable illness just as they accept malaria, or pneumonia as such."

Thanks to John Umstead and others of his colleagues, North Carolina has come a long way in providing better facilities and services for its emotionally ill and mentally deficient citizens. There are still many equally urgent social problems in the State which need action. If past performance is any indication, the "gentleman from Orange" will be tossing a good many more important pieces of legislation into the Assembly's hopper in coming years.

Alcoholics Anonymous

(Continued from page 12)

which they described the early members. The book, *Alcoholics Anonymous,* gave the movement a name and brought it to the attention of people all over the country who wanted to recover from their alcoholism. Growth of AA since the early days has been phenomenal. There are over 4,000 groups in the United States and Canada with well over 120,000 active members. Groups can be found scattered over the world in more than 50 countries. There are more than 80 groups in North Carolina.

Alcoholics Anonymous has a central service office in New York, but it has no national officers, no constitution, no rules beyond the original Twelve Steps and a set of Twelve Traditions, which guide its members and groups according to the spirit of the fellowship. A Board of nine trustees, organized as the Alcoholic Foundation, is maintained to facilitate cooperation between various groups and to provide literature and counsel for groups where such is desired. All aspects of the program are financed by the members themselves.

Loosely-Knit Group

Every local AA group is a loosely-knit voluntary fellowship of alcoholics. Their one purpose is to help one another live sober and purposeful lives. Men and women of all ages belong to AA. Since alcoholism is no respecter of persons, they come from all sorts of backgrounds, rich and poor and from every profession and occupation.

Helping Others

Working without pay to help other alcoholics, known as "twelfth step work," is considered to be an important factor in preserving each member's sobriety. The approach which an established AA member uses with his prospect is not a cut and dried one. The advantage of being an alcoholic himself helps him establish a feeling of fellowship. Many new AA members are attracted by this novel approach, and are thus helped on the road to sobriety.

Anyone who sincerely wants to lick his alcohol problem may call on Alcoholics Anonymous for help. The AA telephone number is listed in many phone directories or further information about AA may be obtained by writing the N. C. Alcoholic Rehabilitation Program, Box 9118, Raleigh, North Carolina.

DOCTOR'S ORDERS

"I thought the doctor told you to stop all drinks."

"You don't see any getting past me, do you?"

Seeing is Believing

(Continued from page 6)

may look at one of the films on personality development and see his own childhood. A mother at a PTA meeting may, on looking at the same film, understand how she has been hindering her child's efforts to achieve emotional maturity. In both cases the same movie can have a salutary effect. The film helps to generate the self-understanding which can put the alcoholic on the road to recovery. It should aid the parent in removing some of the roadblocks to the child's maturity, thus immunizing the child against the development of alcoholism in adulthood.

Enthusiastic Response

Enthusiastic response has come from groups using the ARP films in their meetings and classes. Their letters to Film Librarian, Mr. Roger Whitley, indicate the effectiveness of visual aids. A teacher of an eighth grade Health Class writes that the films on alcohol facts were an ". . . enjoyable learning experience" for her class. A teacher of psychology writes, ". . . the films (on emotional development) have been of great significance to my classes."

The Program Chairman of a Methodist women's group had praise for the ARP film service. She writes, ". . . the film, Alcoholism, helped the members of our Women's Society of Christian Service to increase our knowledge and understanding of the illness."

A teacher of sociology using visual aids in his classes, calls the film, Emotional Health, ". . . one of the most effective movies I ever saw. The students were greatly interested."

Whether tied in with treatment or used to educate the public as a preventive measure, films on alcoholism and personality growth are proving useful tools in advancing the work of the N. C. Alcoholic Rehabilitation Program.

A History of American Drinking Customs

(Continued from page 9)

chusetts Bay had as a part of its cargo for the colony two hogsheads of cider and 42 tons of beer. In 1637 Captain Sedgwick of the Massachusetts Bay Colony built the first brewery in America, and the industry came to rank next in importance to milling and baking. Here in Massachusetts, as in England, the good housewife was judged as much by her ability to make a good batch of beer as to bake good bread.

The Puritans, it seems, neither scorned nor prohibited the use of intoxicating beverages. They did, however, urge sobriety in drinking, and dealt severely with inebriates. The hapless offenders against the code of moderation were often ordered to wear a red "D" around their necks for a year, and many had to pay fines, or to sit in the stocks. Next-door Plymouth Colony dealt more severely with those who stepped over the bounds of sobriety, and public whipping

YOU CAN'T FORCE HIM

IT must always be remembered . . . that there is no substitute for the person's desire to recover from alcoholism. This cannot be forced on a person. An alcoholic, like other people, must decide for himself what he wishes to do. Such a choice can only be made by a person in his own thinking and feeling.

—Ernest A. Shepherd, Administrator,
Florida Alcoholic Rehabilitation Program

was their punishment.

During the latter colonial period and up until the Revolutionary War, the manufacture of liquors was a growing industry in the colonial economy. The manufacture of beer, cider, ale, brandy, and whiskey was often carried on as a household industry. There was a great demand for these beverages, for it seems that our ancestors indulged quite freely their thirsts.

Drank Much Wine

George Washington, the Father of our Country, seems to have been very much in step with the drinking customs of his time. We read that ". . . General Washington notwithstanding his perfect regularity and love of decorum could drink more wine than most people. He . . . made it a rule to drink a glass of wine with everyone at the table and yet always drank 3-4 more glasses of wine after dinner, according to his company . . . "

As in the other colonies in Early America, drinking was an accepted and widespread custom in our own State of North Carolina. Small farmers made up the bulk of the population here. These men worked long and hard with their own hands. When time came for play and amusement—the infrequent court sessions, holidays, and militia musters—they played and drank hard.

Legislation Passed

Over-indulgence in alcoholic drinks became such a serious problem in the colony of Carolina that the colonial legislature of 1715 took action to try and reduce it. That assembly passed a bill which, among other things described drunkenness as being the "root and foundation of many enormous sins" in the colony and decreed a fine of five shillings for anyone caught intoxicated on the Sabbath.

Despite attempts to legislate them away, periodic bouts of hard drinking, "frolics" they were called, remained a part of the North Carolina scene. These generally took place on holidays, when the militia gathered, or during court week, In fact, no holiday was thought to have been properly celebrated unless one got a little drunk.

Drinking continued to be the rule in North Carolina throughout the 1700's. All manner of gatherings—from horse races to funerals—seemed to offer adequate excuse for the lifting of a convivial glass. In 1775 a hogshead of rum was rolled out for the entertainment of guests at the funeral of a resident of Point Pleasant, near Wilmington. In 1767, seven gallons of whiskey were consumed at a funeral in Mecklenburg County. And it was quite the custom in North Carolina, especially among the more prosperous planter class, to have something to drink before breakfast—egg-nog, cherry-bounce, or gin. Liquor was thought by our North Carolina predecessors to have a medicinal effect, and a drink before breakfast was often taken to sharpen the appetite, and to ward off the fevers. In fact "fretful babies were soothed with a teaspoonful of diluted liquor, reputed to be a certain cure for the colic."

County Fairs

After the turn of the 18th century, the county fair took its place as one of the more lively events of a somewhat meager schedule of social gatherings. Considerable inebriety marked the fairs of this era. In fact, disorderliness was so common that some counties were forced to discontinue their fairs. They were tabbed by some, "sinks of iniquity,"

and were thought to attract all the undesirable persons from the surrounding countryside.

The custom of imbibing was apparently not unknown to the "better" young men of the day whose parents were able to send them to academies for schooling. One of the better known of these academies included among its rules of punishment eight strokes of the lash to those "Drinking Spiritous Liquors at School."

Quantities Produced

Our North Carolina ancestors not only accepted the everyday use of alcoholic beverages, but with an enterprising zeal also produced quantities of the products by which the custom was practiced. In 1840, North Carolina produced over a million gallons of fermented and distilled liquors, outstripping Eastern Virginia and South Carolina in volume produced.

During the period of our history when the frontier of Dixie began its westward advance, alcoholic beverages were in common household use on the frontier. Hospitality demanded that some drink be offered any visitor. Hard liquor was often used at the frontier table as tea or coffee is today.

Flowed Freely

At the turn of the 19th century and onward through the 50's whiskey flowed freely among the mountain men and the soldiers on the Rocky Mountain Frontier. The periodic return to their settlement of the fur trappers in that untamed country saw an occasion for prolonged dissipation, marked by drunkenness, gambling, fighting and general tumult. The trapper frequently squandered all his money during these periods.

Soldiers on the frontier posts led weary, isolated, dragging existences. Liquor furnished them practically the only available escape from this monotonous existence. As a matter of fact, for a period in our history whiskey was issued as a part of the soldier's ration. One of the most common forms of punishment for the frontier soldier's misconduct was the withholding of his liquor ration.

On the Northern Plains frontier—in Kansas, Nebraska, and the Dakotas—saloons were more numerous in many towns than any other type of business establishment. In Fargo, Dakota Territory, in 1886, for example there were sixty saloons. In the same year Hay Springs, Nebraska, population one hundred, had three grocery stores and three saloons.

Hard-Drinking Cowboy

The frontiersman gave way to the equally hard-working, hard drinking cowboy. Living a lonely existence on an isolated ranch, the cowboy, whose life in reality lacked the glamour attributed to it in motion pictures and novels, drank away his boredom upon his infrequent visits to town. More often than not this was the only amusement available to him and he used it strenuously. Upon returning from the "long drive" to the eastern cattle markets in the 80's, 90's, and early 1900's, cowboys and cattlemen alike celebrated their wealth by "drinking up the town."

We can see that liquor played a prominent role in the life of the frontier—both on the supper table and in the saloon. Like "chips off the old block," the frontiersmen continued the drinking tradition handed down to them from the colonial fathers.

HOLD THEM AND LOSE THEM

SO many parents do not know that the way to keep a child's love is to be interested in the child for the facilitation of its own growth and development. Trying to hold their children, they so often drive them away—that is, if the child, for its own salvation, succeeds in escaping.

Leon J. Saul, M.D. in *Emotional Maturity*

Why People Drink

(Continued from page 7)

ables them to live in peace and contentment with themselves and other people and to face the barbs realistically. They have both self-respect and a realistic attitude toward their abilities and their shortcomings. They get satisfaction from simple, every-day pleasures.

They are able to love, and they have a capacity to receive love. They neither push other people around nor allow other people to push them around. They are on good and satisfying terms with their friends and neighbors to whom they have a sense of responsibility. They realize that there are many differences in people, but they can respect these differences.

Act Responsibly

These people accept responsibilities. They have an optimistic view toward the future. The goals which they set for themselves are based on reality, not impossible ideals. They are able to think for themselves, and they do something about their problems rather than continually worry about them.

These are some of the characteristics of people who enjoy good emotional health.

Do these people drink alcoholic beverages? If so, why? We have already stated that people drink alcoholic beverages primarily for their effect on feelings or attitudes. We have also stated that these are the kind of people who feel comfortable and happy most of the time. Nevertheless, many well-adjusted people drink. *But they are not likely to be alcoholics.* Alcohol cannot give emotionally healthy people the degree of satisfaction that it gives to people who become addicted to its use. The reason is this: The well-adjusted, emotionally healthy person has no great need to feel more comfortable than he *usually* is.

Social Pressures

If he drinks it is because of social pressures and customs, his need to be a part of the group, and the common human wish to be like the group—not different from them. The members of his group do not habitually drink to excess, although they may at some time become intoxicated. For them, and for him, alcohol is a social lubricant. Because of his social values and the other things he lives by he does not belong to a group which gets together for the prime purpose of getting intoxicated. Alcohol is not really important to his way of living.

Problem Drinking

But let us examine another type of drinker and his reasons for drinking—the problem drinker. He drinks more regularly and more heavily than the social drinker. He likes to think that he too can take it or leave it alone, and he probably can leave it alone completely if he determines to do it. But he likes the "glow" that alcohol gives, and he usually drinks to some degree of intoxication, either alone or with the group.

He manages to hold on to his job without serious difficulty though he may occasionally come to work with a hangover, and he even has a sense of responsibility toward paying the bills first. So long as his drinking does not increase to the extent that his personal, social, and financial obligations suffer, he appears to be a fairly well integrated personality.

Nobody—least of all himself—seems to consider the very real possibility that

he is perched precariously on the borderline between social drinking and the illness of alcoholism. He may not eventually cross over the line. Here again "the need to feel more comfortable than he usually is" comes into the drinking picture. But for this drinker the need is greater and the reaction to the need is consequently more marked. Social pressure is the excuse, not the real reason why this man drinks, although it may have some bearing on his drinking.

Drinks For Effects

He drinks consciously and purposely for the effects of alcohol on his feelings and attitudes. These feelings may be vague and hard to define, such as a dim awareness of being ill at ease. They may be expressed as fatigue, as muscular tension, or irritability. In either event they are uncomfortable feelings which he wants to relieve. He has these feelings just about as often as he has comfortable feelings. On the surface he appears to be well adjusted, but it is a borderline adjustment. He may eventually lose control over the amounts *and* times he drinks. His continued excessive use of alcohol, makes him feel temporarily comfortable but offers no realistic adjustment to his problems.

But what about people who definitely feel *un*comfortable or *un*happy most of the time? These people are emotionally unhealthy. Their uncomfortable feelings are more intense than those of either the social drinker or the problem drinker. (Remember that the problem drinker can lose *his* emotional balance and become emotionally ill—highly susceptible to rapid development of alcoholism.) Their feelings demand some kind of release, which may be through excessive drinking, in which case the person is likely to become an alcoholic.

All emotionally unhealthy people, however, do not drink. They may release their intense feelings and achieve more comfortable feelings through other personal excesses or channels: chronic nagging or complaining, intense drives toward overwork or sex activity, a neurotic need to control or exploit others, an overpowering compulsion to eat excessively, for example.

Or they may keep their uncomfortable feelings to themselves, never indulging in excesses of any kind, wearing the mask of normality, only to find that emotional ill health *must* express itself by some symptomatic reaction.

Turns Inward

If the symptom is not expressed outwardly, where it can be recognized, as in alcoholism and cases described, it turns inward and attacks the body. Emotion creates energy, and energy must be released in some manner!

By analogy think of the mind and body as a boiler. The emotions furnish the fuel which creates the steam (energy) in the boiler. The hotter the flame the greater the pressure of steam in the boiler. As the pressure rises it seeks an outlet (safety valve). Emotionally healthy people have good safety valves for "letting off steam"—hobbies, recrea-

ARE YOU GETTING ANYWHERE?

THE mentally healthy individual must want to achieve specific goals. Motivation is usually multiple for most of us: we want to have a home and a family; we want to do our jobs well; we would like to achieve in a certain field; we want to enjoy ourselves in our recreation. Insofar as one's judgment is good in the choice of those goals, the strength of one's personality can be judged by the persistence and forcefulness of determination.
—William C. Menninger, M.D. in *Psychiatry in a Troubled World*

tion, numerous other socially acceptable and satisfying activities, plus the ability to release steam through problem solving.

In the emotionally ill person these safety valves are not in good working order, so the steam seeks other outlets, however personally undesirable they may be; alcoholism, hypochondria, kleptomania, etc. But many personalities (boilers) will not, or cannot, release steam through these substitute valves. The steam remains bottled up and the pressure rises until finally the boiler explodes.

Inward Symptoms

This is exactly what happens to the emotionally ill person whose energies do not find expression through outlets of any kind. The energy eventually finds expression within the body. These inward symptoms (explosions) of high emotional pressure are sometimes recognized as peptic ulcers, asthma, certain forms of heart trouble, high blood pressure, skin diseases and eruptions, or many other "physical" illnesses which if not wholly attributed to emotional causes are certainly partly so.

When the emotionally ill person turns to alcohol to relieve the pressure of his uncomfortable, unhappy feelings, he finds especially rewarding relief unless he has already developed a symptom which for some undiscovered reason his particular personality is prone. Even so, many emotionally ill persons have been observed to switch from one symptom to another, as from skin diseases to asthma, or from alcoholism to peptic ulcers and vice versa. The exact process by which this happens is not understood. Neither does science fully understand why one person develops ulcers while another develops alcoholism or asthma from apparently similar emotional causes.

The important thing to remember is that alcoholism is a symptom of emotional illness. Alcoholism is a substitute safety valve for emotional pressures, and it is used only because the "good" safety valves are not working as they should. This gives us the clue to successful treatment of alcoholism, whether that treatment involves individual psychotherapy, group psychotherapy, Alcoholics Anonymous, pastoral counseling, or case-work services. *The good valve must be opened and the substitute valve must be closed.* The alcoholic cannot be expected to do this by himself, but it cannot be done without his sincere desire that it be done and without his wholehearted cooperation. It is not a simple task, for the alcoholic's uncomfortable feelings are deep and chronic and should not be expected to change over night.

Only Partly True

It has often been said that all alcoholics begin their drinking careers as social drinkers. This is only partly true. There are many cases on record where excessive, compulsive, *alcoholic* drinking developed almost from the first drink, often late in a life of complete abstinence, sometimes as young as 14 or 15 years of age. As has been explained only a relatively small percentage of the "social" drinkers develop alcoholism—around 6 per cent of the total number of drinkers. Whether or not a social drinker remains a social drinker or eventually loses control over his drinking seems to be determined by the strength of his inner resources, including his particular stage of emotional development, plus an "X" factor which may or may not lie in

the physical makeup of the person prone to alcoholism.

The comfortable, well-adjusted, emotionally healthy individual who drinks is apparently in no danger of becoming a compulsive, uncontrolled drinker unless subsequent life experiences so tax emotional stability that he develops an emotional or mental illness. This statement may call for some clarification. Psychiatrists tell us that every man has his breaking point; he can undergo just so much stress and strain, and then he collapses. The Russians have used this idea to perverted advantage in their "brain-washing" techniques and in deliberately breaking down the mental stability of prisoners whom they wish to "confess" to crimes against the Soviet Union. Less dramatic but more prolonged personal and social experiences shake and sometimes destroy emotional stability in adults.

Hard To Determine

Because numbers of people who drink —emotionally healthy and otherwise— experience intoxication at one time or the other, it is difficult to determine on short observation the degree and depth of the uncomfortable feelings responsible for the drinking.

The normal individual whose sweetheart just jilted him might go out and get roaring drunk, but he will not develop compulsive drinking on that account. Should his business go bankrupt he may go to the nearest bar and drink until he slides from the barstool, but he will find a way to make a living after he sobers up. These are temporary uncomfortable feelings, painful, crying for relief, greater than usual relief perhaps, and although the emotionally mature, normal individual may turn to alcohol under the circumstances, it is for temporary relief only. His inner resources will enable him to adjust satisfactorily to the problem after the initial shock.

Won't Adjust Quickly

The person whose emotional discomfort is deep and long-lasting might also get drunk under the circumstances—most certainly he would if he drinks at all—but he will not adjust satisfactorily or quickly to the shock of losing his sweetheart or business. The normal person was emotionally upset, and he reacted emotionally to the problem, but he quickly regained his emotional stability, faced the problem realistically, and solved it with reason. This relieved the emotional pressure that always results from an unsolved problem.

The emotionally ill drinker under these circumstances wants to solve the problem but he is unable to face the issue realistically. His perspective of the problem is distorted by his uncomfortable feelings —just as the normal individual's perspective was distorted temporarily—but we must remember that this drinker has *usual* uncomfortable feelings. When he

NOTABLE QUOTES

No Man can justly censure or condemn another; because, indeed, no man truly knows another. This I perceive in myself; for I am in the dark to all the world, and my nearest friends behold me but in a cloud.—*Thomas Browne*

Have patience with all things, but chiefly have patience with yourself. Do not lose courage in considering your own imperfections, but instantly set about remedying them—every day begin the task anew.—*St. Francis*

The secret of contentment is knowing how to enjoy what you have, and to be able to lose all desire for things beyond your reach.—*Lin Yutang*

Every man knows that others are mistaken in their judgment of him, but not that he is mistaken in his judgment of others.—*Andre Maurois*

Are you angry that others disappoint you? Remember, you cannot depend upon yourself.—*Benjamin Franklin*

sobers up he is little closer, if any, to solving the problem than he was before.

His uncomfortable feelings continue to hinder and block constructive action or satisfactory adjustment to the situation, so he worries and broods. Since he cannot solve the problem or adjust to it his impulse is to escape from it, and alcohol is his most satisfactory avenue of escape. Like the person who gets "tight" whenever he has a head cold, he knows that alcohol won't help him get well any quicker, but it relieves the aches and pains temporarily.

Tragic Experience

The person for whom alcohol represents the usual and surest means of escape does not need to have a tragic experience to set off the drinking, of course. He considers life itself a tragic experience. Every day he must make decisions, accept responsibilities, talk with people he doesn't like, do things he doesn't want to do, and spend the evening in loneliness or in boredom. He has to get up in the morning and go to bed at night. He is filled with remorse about what he did yesterday and he is worried sick about what tomorrow will bring. He hates himself for not doing the things he should have done, and he hates himself for doing the things he did but shouldn't have. This is the world as he sees it, the world in which he must live, and he doesn't like it. He has tried to adjust to it, and he has failed. To him the only alternative is escape through alcohol.

Drowns Frustrations

Alcohol drowns his frustrations, his remorse, his bitterness and hate, his loneliness, and his anxieties about the future. He knows that when he sobers up his uncomfortable feelings will return to plague him, and that the inevitable hangover will add to his misery. Nevertheless, his need for escape is so great that he cannot resist alcohol; he must have relief, temporary though it is. He is a thoroughly sick person whose basic emotional problems will continue to make life miserable for him until: (1) he accepts the fact that he is suffering from an illness; (2) he sincerely desires help in recovering from this illness; and (3) he is willing to cooperate with the people who can help him to recover.

These are sick people, suffering from an illness just as real, just as progressive, just as destructive as cancer or tuberculosis. They can recover from this illness only with the help of others.

Problem drinking, or alcoholism, is not merely the problem of the person whose drinking gets him into diffiiculties. It is a family problem, a community problem, a state problem, and a national problem. It is a problem which can best be solved through the cooperative services of laymen and professionals whose experience, interests, and training, qualify them for the job of helping problem drinkers achieve permanent sobriety and peace of mind. These are the family doctors, the social workers, the psychiatrists, the ministers, and the recovered alcoholics. Just as important is the understanding and help of the person nearest and dearest to the problem drinker.

How To Help An Alcoholic

(Continued from page 11)

light, a most important factor to the recovery to someone dear to you.

Here are a few liabilities you can watch and a few assets you can strive for: Liabilities—self-justification, self-importance, envy, hate, resentment, false pride, jealousy, insincerity, negative thinking, criticizing, dishonesty. Assets—humility, modesty, self-valuation, patience, love, forgiveness, trust, activity, straightforwardness, positive thinking. As you write you will undoubtedly think of many more.

After taking your 'inventory' we will assume that you now know yourself a little better. It was probably a bit painful but it was a big step forward for you and the person you want to help.

The wife of an alcoholic recently penned this sage advice: "If you are a trembling recluse, rejoin the human race." A good place for you to start rejoining is the nearest Alcoholic Anony-

mous group. There is one near you; look in your phone directory. Every AA group has open meetings. The general public can attend. Many AA groups have a wives' affiliate. If the group in your town has one, join it. Other wives of alcoholics have had experiences similar to your own. They will understand; they will help you. If there is no wives' affiliate an AA member will be glad to talk with you about your husband's problem at the open AA meeting. You may also want to discuss the matter with a minister who has a good understanding of alcoholism. If you are in doubt about which one to see, ask the AA member. He will know. Talking about your troubles with people who understand rather than with people who give you nothing but sympathy will help you to develop peace of mind and confidence in the future.

He Is Sensitive

You may wonder why nothing has yet been said about talking directly to your husband or wife about problem drinking. As you know he is sensitive about this subject. He has not felt that you understand his drinking or him; consequently your conversation in this regard has been so much water off a duck's back. If you have achieved real understanding and have shown some improvement in your attitudes, you may now be able to approach him on a level that he will not resent.

Do not make the fatal mistake of bringing up the subject while he is drunk. His thinking is distorted at that time; he may lie to you, and he cannot be expected to keep his promises.

In the first place don't ask him to make any promises. Tell him simply, honestly, and without any display of emotion that you have been studying something about alcoholism in the hope that you could understand and be able to help when and if he decides that he wants to stop drinking.

Don't go any further than that. Just leave him with the impression that you want to help him when and if he wants help. He may want to discuss the matter further, and if he does, calmly answer his questions to the best of your ability without getting emotional. Should he become emotional stop the discussion; it is extremely difficult for a person to be highly emotional and reasonable at the same time. Wait until he is in a more reasonable mood. Don't be discouraged.

Changed Attitude

He may wonder about your change of attitude. He may accuse you of airing the family's troubles all over town, but he probably will respect you when you tell where you have aired your troubles and why. He should never be made to feel ashamed of his illness, but he should feel your confidence that he will seek treatment for alcoholism sooner or later just as he would seek treatment for pneumonia or tuberculosis.

Don't push or nag him into accepting treatment. A person who is coerced into accepting treatment has an extremely slim chance of benefitting from it. It would merely be a waste of time or money. Alcoholics Anonymous will not accept him until he sincerely wants to achieve and maintain sobriety. The Treatment Center of the N. C. Alcoholic Rehabilitation Program will require him to express voluntary desire for treatment before he will be admitted.

Should he express no interest in accepting treatment at this time, drop the

ALCOHOLISM BUT A SYMPTOM

Alcoholism is practically always a symptom of an important, underlying psychiatric maladjustment. This relieved, alcoholism may disappear of its own accord.

—Charles C. Wilson, M.D. in *Health Education*

subject. You may have accomplished more than you realize. Your change of attitude, your refusal to allow his drinking to disrupt what peace of mind you may have attained, will start him thinking.

Wait a day or so and casually leave some of the literature you have read where he may notice it. After supper some evening or while you are at the movies or visiting he may decide to read it. Many alcoholics have been led to understand the nature of their compulsive drinking in this way and subsequently accepted treatment.

Don't Make An Issue

Should he begin to show interest in treatment try not to act surprised; don't be tearful; don't make an issue of it. Only he can make the decision to accept treatment. Let him make this decision as any mature adult would; don't try to take credit for it. Don't rush out to make the arrangements either. Accompany him if he wants you to go along, but don't force yourself on him.

While he is at the treatment center you must guard against any attitude of victory. The fight has just begun! Recovery from alcoholism is a long time proposition. The attainment of sobriety is just a part of the victory. Victory consists of many parts, some of them taking possibly a lifetime to attain. Among these are peace of mind, social readjustment, and a rebuilding of all the life areas which have been damaged through years of compulsive drinking. These goals apply to you as well as to him. For that reason you should seriously consider ways and means of reaching these goals yourself. Your loved one's sobriety will not give them to you. Sobriety by itself is only a start toward these goals for him.

While he is at the treatment center he will learn a great deal about himself, his emotions, his reasons for reacting inadequately to life's problems. If treatment is successful he learns to face life experiences without chronic emotional distress, and without the compulsion to drink. He may come home a more mature person, a more self-respecting and self-confident person.

Readjustment

All this will take a quick readjustment on your part. You took your personal inventory before he went to the treatment center. You talked with your minister perhaps, and with members of Alcoholics Anonymous. Your attitudes were changed somewhat, but were they changed enough to enable you to adjust to this sober, slightly changed personality that looks like your husband or wife but who somehow seems different. Many wives of recovered alcoholics find this to be a difficult and stressful situation.

Prepare Yourself

If you happen to be the wife of an individual who is about to accept professional treatment for alcoholism, would it not be a good idea for you to be adequately prepared to meet him on the same emotional level when he returns as insurance against continued strife? That help is available to you no matter what your financial status at your nearest Mental Hygiene Clinic. Show your mate that you are willing to meet him half-way. When he goes to the treatment center, make an appointment for yourself at the nearest Clinic.

Then, when he returns home you will be in a better position to develop and maintain a healthy emotional atmosphere in your home. This is the greatest gift you can give him.

EYE OPENERS

Capsule information

and comment

The NCARP has recently published Dr. Norbert L. Kelly's research study of the social histories of 250 former alcoholic patients at the N. C. Alcoholic Rehabilitation Center. Among other things, Dr. Kelly has turned up some interesting facts regarding the recreational interests of these men. Analysis of 217 of the 250 histories shows that the most frequently-noted type of recreation was reading. Spectator sports were the second most popular type of recreation among the patients studied. Only four of the group attempted hobbies which could be pursued the year round. Only eight per cent of the patients indicated participation in competitive sports. Active recreation and creative hobbies can provide ready avenues for draining off the effects of life's setbacks. Dr. Kelly's study shows that these two fields of tension-relieving activity were little used by alcoholic patients before coming to Butner.

The Supreme Court of North Carolina, in discussing the meaning of the phrase "under the influence of liquor" as defined in Black's Law Dictionary, concluded that ". . . the legislature did not intend to make a distinction between a person who is drunk and one who is under the influence of liquor . . . A person is under the influence of intoxicating liquor . . . within the meaning and intent of the statute, when he has drunk a sufficient quantity of intoxicating beverage . . . to cause him to lose the normal control of his bodily or mental faculties, or both, to such an extent that there is an appreciable impairment of either or both of these faculties."

Modern psychologists attribute great wounding power to words and healing strength as well. For this reason we should be very careful about the words we use in connection with alcoholic illness. Instead of "alcohol addict" we should say "problem drinker," for example. Instead of "drunk" we should say "intoxicated," and for 'drunkard" substitute "inebriate." The terms addict, drunkard, and the like carry a traditional stigma and tend to make the alcoholic feel even more isolated from the public. As a result of research, we know that the problem drinker is a sick man, and we should avoid using terms which are not in line with this idea.

Alcoholism is an illness and, as such, presents itself for treatment in every doctor's office in North Carolina. A physician, naturally, has his likes and dislikes, and he may shy away from any alcohol problem just as some doctors shy away from specific medical or surgical problems. The family physician should take the same attitude toward cases of alcoholism as is required in the management of any other disease. First of all, he must recognize the problem. Secondly, he must start proper therapy himself or see that his patient is referred to some other treatment source in the community. These may include (1) a hospital which accepts cases of acute alcoholism for treatment; (2) another physician who has had more experience in treating alcoholics; (3) a community outpatient psychiatric clinic; or (4) an inpatient treatment center, such as the ARC at Butner.

Alcoholism is not due to a lack of will power. Alcoholics are among the strongest willed people in the world. Family, job, social standing, money, mean little to the alcoholic when he has the will to drink. He will let almost nothing stand in his way. Alcoholism is an emotional illness. Because the alcoholic does not understand why he is compelled to drink, he must have help from others in order to recover.

Whether beer, wine, or whiskey, what you're drinking is

BEVERAGE ALCOHOL

ALCOHOLIC beverages may be divided into three main groups: wines, brewed beverages, and distilled spirits. Of the three, wine is the easiest to make and was probably in use long before the other two were known.

Wines are made by the fermentation of sugar in fruit juice which has been allowed to stand in a warm place. Yeast is the agent which causes the process of fermentation. During this process bubbles of gas (carbon dioxide) and alcohol are formed. Fermentation usually stops when the concentration of alcohol approaches 15 per cent. Wines having a higher percentage of alcohol by volume (up to 21 per cent) have been fortified by the addition of distilled spirits. A slang expression sometimes given to fortified wines is "Sneaky Pete."

Brewed beverages such as beer and ale are also products of fermentation but the process of making them is more complicated due to the more complex sugar structure in the cereals from which they are made. Actually, ale is beer, but it is stronger and heavier than the product generally sold as beer. Beers and ales contain approximately 4½ per cent alcohol by volume.

Distilled spirits are made from liquids which have been fermented or brewed. Distilling vaporizes the liquid and then condenses it, thereby greatly increasing the alcoholic content of the product. Gin, whiskey, brandy and rum are made by this process. Whiskey is made from grains such as corn, wheat, or rye; rum is made from sugar cane and its by-products of sugar, syrup or molasses; brandy is distilled from wines and fruits; and gin is the product of neutral spirits to which juniper berry, roots and herbs, or other flavoring material has been added. Distilled spirits vary in alcoholic content from 40 per cent to 55 per cent.

A distilled spirit which is 100 per cent alcohol cannot be considered beverage alcohol by law, and also because it would be too strong for drinking purposes. When a whiskey or other distilled beverage is labeled "100 Proof" it means that it contains 50 per cent alcohol. "90 Proof" whiskey contains 45 per cent alcohol and consequently is not as strong as 100 proof.

Books of Interest

DRINKING'S NOT THE PROBLEM

By Charles Clapp, Jr.
Thomas Y. Crowell Company
New York, N. Y. 179 pages
$2.50

While reading this book, I couldn't help thinking about the case of one alcoholic who gave up a job that really interested him—craftwork—for the boring railroad job that paid a lot more money. Liquor helped him to ease his boredom and forget his creative urge.

If only he had continued his craftwork as an avocation while railroading, life may well have been more satisfying, more stimulating. He may not have needed the bottle to dress up a drab, monotonous existence.

The significance that such constructive avocations may have for one striving to avoid alcoholism is one of the engaging principal themes of Clapp's book.

Written principally for the problem drinker, that is the pre-alcoholic, it contains much wisdom for all of us.

The author recounts enlightening portions of his own life history. Basically, he was confused and unhappy, with a profound fear of the future. His perfectionist father, never satisfied with his son's achievement, did not help the boy gain a sense of adequacy, or self-confidence. This feeling of being unable to do anything confidently, always afraid that he would fail carried right through into adult life.

Drinking could temporarily relieve him of this anxiety. With sobriety, unhappiness always returned.

Religion was the first span in Clapp's bridge over his alcoholic abyss. From a newly-awakened spiritual belief, he gained confidence in himself and an assurance to face his problems.

A friend helped him to discover interests that had been lying dormant. These led to a new, more satisfying occupation, a totally different environment for home and work.

Clapp underwent rewarding psychiatric treatment. With guidance he developed true insight into the emotional problems which underlay his illness. He came to understand them, to recognize them when they recurred. And he learned to control them.

He joined AA, and received the understanding and support always found in that excellent organization.

At the writing of the book, he was happy, secure, and sober.

Throughout the entire book, the emphasis is on the need for change—if the problem drinker is not going to become the alcohol addict.

Emotional change must come first. Attitudes and values must be modified. Some form of religious security must replace spiritual diffidence. Latent desires must be brought to conscious awareness and acted upon.

The admissibility of change of occupation and of home is analyzed also. Clapp cautions against haste in these life areas. Never, he writes, should they be undertaken first or by themselves. The constructive change must always come first in the emotional life of the pre-alcoholic. In turn, this modification may or may not motivate occupational and environmental change.

For those who know little or nothing about alcoholism this book will provide much basic knowledge. Many members of AA may profit from it also. And let us hope that it will come into the hands of those for whom it was primarily written — those poised on the teetering edge of addiction—the potential alcoholics.

—Norbert L. Kelly, Ph.D.
Education Director

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
415 Halifax St.
RALEIGH, N. C.
Phone: 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: 3-8343
Monday through Friday

Mental Hygiene Clinic
210 N. Greene St.
GREENSBORO, N. C.
Phone: 3-9426
Also at HIGH POINT
Phone: 8929
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
Chapel Hill, N. C.
Phone 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: 3-5441 & 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: 3-2471, Ext. 29
Monday through Friday

Graylyn Hospital
WINSTON-SALEM, N. C.
Phone: 3-7391

FRIDAY ONLY. This is purely a Clinic for alcoholics and their families. Out - patient mental hygiene clinic is located at Baptist Hospital, Winston-Salem.

Toward helping patients to re-establish satisfactory social relations all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly journal using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The Butner Brochure—illustrated 36-page book on North Carolina's program of treating alcoholism as an emotional sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Kits—kits containing books and pamphlets on alcoholism. Available to libraries from N. C. Library Commission, State Library, Raleigh.

Book Loan Service—kit of reference works on alcohol and alcoholism, for high schools. Order from Education Director, Box 9118, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
Box 9118
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

SEPTEMBER, 1954

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

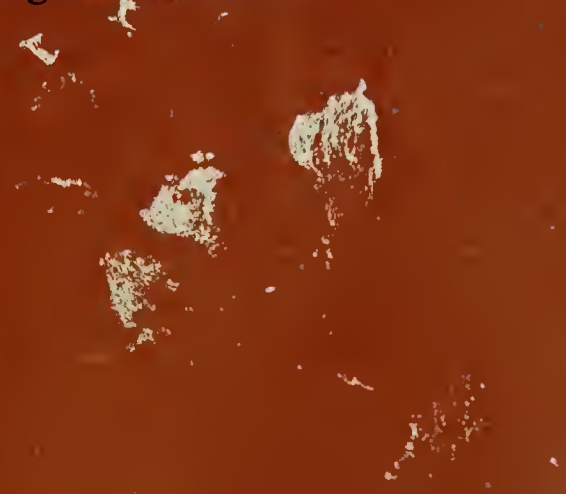
PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION



N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $72 for 28 days' stay.

Butner Treatment Methods

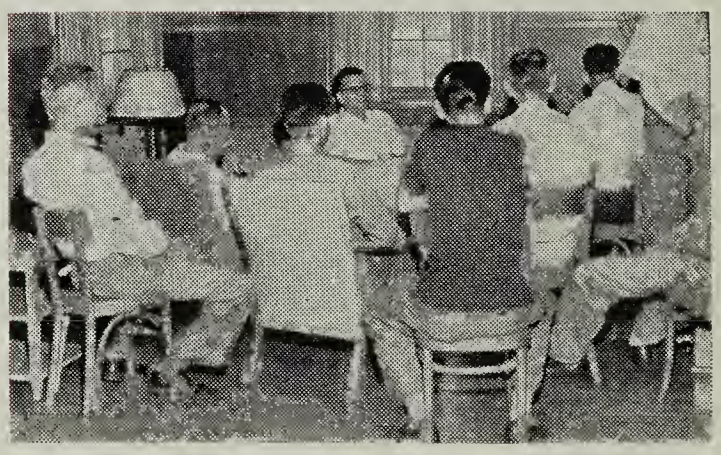
Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, a social worker, a recreation director, an occupational therapist, and ten attendants.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.
2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.



3. A fee of $72, in cash or certified check, must be paid upon admission.
4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illnesses. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
8 A.M. to 11 A.M. Saturday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

S. K. PROCTOR

Executive Director

NORBERT L. KELLY, Ph.D.
Educational Director

LORANT FORIZS, M.D.
Clinical Director

INVENTORY

VOLUME IV — NUMBER 3

SEPTEMBER, 1954

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices, 15 West Jones St., P. O. Box 9118, Raleigh, North Carolina.

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Circulation This Issue: 17,000

This journal is printed as a public information service. Persons desiring a place on the free mailing list must send in a written request. This journal will not be sent to persons other than those requesting it.

Write: INVENTORY, Box 9118, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

Inventory Helpful

I have just received the July issue of INVENTORY. I was placed on your mailing list while I was Judge of the Recorders Court of Wilson. I do hope that you will continue my name on your mailing list as I have found this magazine very helpful in dealing with several problems here and have intended writing you for sometime and congratulating you on the splendid work which you are doing in this field in North Carolina and elsewhere.

Charles B. McLean
Attorney at Law
Wilson, N. C.

Clinical Director Lectures

After Dr. Lorant Forizs gave his series of excellent papers here recently at the clinical conference on alcoholism, I saw a copy of your publication, INVENTORY, and if it is possible I would appreciate being put on the mailing list for this publication to learn more regarding your program in North Carolina for alcoholics.

Paul E. Davis, M.D.
State Hospital
Salem, Oregon

Forward—Looking Program

I am greatly interested in the work which your organization is doing and am advised that it has one of the best and most forward-looking programs in our country. For this let me offer you my hearty congratulations and may I ask a favor of you. Would you please put my name on your mailing list for INVENTORY, and also I am interested in receiving the pamphlet, "Alcohol, a Personal and Community Problem."

John W. Richey
Director of Education
United Temperance Movement of Minnesota
Minneapolis, Minnesota

Likes May Issue

My immediate reason for writing you is to compliment you on your recent issues of INVENTORY, especially the one of May, which I have spent the morning pondering. Both from the point of view of literary quality and helpfulness of the material, INVENTORY has achieved a high place. We, with more limited resources and talents, are dependent upon the research and thinking of our more productive neighbors and we want to thank you warmly and sincerely.

John Pasciutti
Supervisor of Alcohol Education
Montpelier, Vermont

Waiting Room Reading

After reading one of your recent issues that a local doctor had, I can truthfully say that it is certainly educational and helpful. I will appreciate your putting my name on the mailing list.

F. B. C.
Rocky Mount, N. C.

Program Pointers

By S. K. Proctor
EXECUTIVE DIRECTOR

THE importance of visual aids in education has been recognized the world over. Accordingly, the ARP is attempting to use visual aids to the fullest extent in its educational efforts. Unfortunately, the existence of good visual aids materials on the subject of alcohol and alcoholism is extremely limited, often biased, and in some instances of poor quality.

Realizing the need for more adequate visual aids materials in this field, we were led sometime ago to study the possibilities of producing a motion picture giving the public factual information about the development and treatment of the illness of alcoholism as we have seen it from our own experience, and based on observation and clinical records.

Preliminary conferences were held with officials of the Radio and Television Center of the Greater University of North Carolina, including the Director of the Communications Center, Mr. Earl Wynn; the Assistant Director, Mr. John Clayton; and Mr. Robert Schenkkan, Director of Television for the Consolidated University.

As a result of these preliminary talks the Director felt that a worthwhile motion picture, one which would simply and graphically get our message across to the people, could be produced by the Chapel Hill group. It seemed to me that with his staff of professionally trained and highly skilled and experienced people, Mr. Wynn was capable of giving us a really professional production.

Members of our staff pooled their knowledge and suggestions as to content of the proposed movie. Our Editor, Mr. Champion, then compiled and integrated all these suggestions, and prepared the preliminary outline of a script. This material was then turned over to Mr. Clayton in Chapel Hill and he began to work on the final script for the production. The finished script, which the author has titled, "Domino," was in my hands early in May. All of our staff agreed that it was a splendid job, and one that had every possibility of working into a fine motion picture.

Castings Made

Recently, the castings were made, with most of the roles going to dramatic arts students at the University. Mr. Bill Trotman, an extremely talented young Playmaker, was chosen to play the principal role of the male alcoholic—and an excellent choice he was!

Filming started during the second week in August, with Mr. Wynn giving his personal time to do the directing. Mr. Wynn's previous experience has included motion picture direction in Hollywood, and the direction of educational training films for the U. S. Navy during World War II. Exceptional talent in direction, acting, and technical assistance has

(Continued on page 29)

Personality Sketches

JAMES L. CATHELL, M.D.

Assistant Superintendent
State Hospital at Butner, N. C.

THE Assistant Superintendent of the Butner State Hospital is a genial man who obviously gets a good deal of pleasure from a job which most of us would find strenuous and taxing. But Dr. Cathell doesn't find his present position any more demanding than the thriving medical practice which he left in 1949 to come to Butner. And, according to him, the satisfactions he gets from helping emotionally ill people to recovery more than make up for the rigors of his administrative duties.

Doctor Cathell's appointment as Assistant Superintendent about a year and a half ago was made primarily to relieve Superintendent Murdoch of some of the staggering list of administrative details connected with operating the 1800-bed State Hospital and the nearby Treatment Center of the NCARP. At the time of his appointment, Cathell had been on the Butner Staff longer than any of the other doctors, with the exception of Murdoch. Dr. Murdoch's increasing reliance on Cathell attests to the Assistant Superintendent's administrative "savvy." And Cathell's loyalty and respect for Murdoch, to whom he affectionately refers as "the Boss," ensures a smooth-working twosome at the hospital's helm.

Many Problems

It would be difficult to describe a typical day for Dr. Cathell, so many and varied are the problems which might confront him during any 24-hour period. One of his important jobs is to conduct staff conferences when Dr. Murdoch is busy with other duties or is called away on other pressing hospital affairs. These conferences deal with new admissions and a treatment program is carefully mapped out by the entire staff. At other conferences cases are reviewed, new therapy considered, or the possibility of home visits considered.

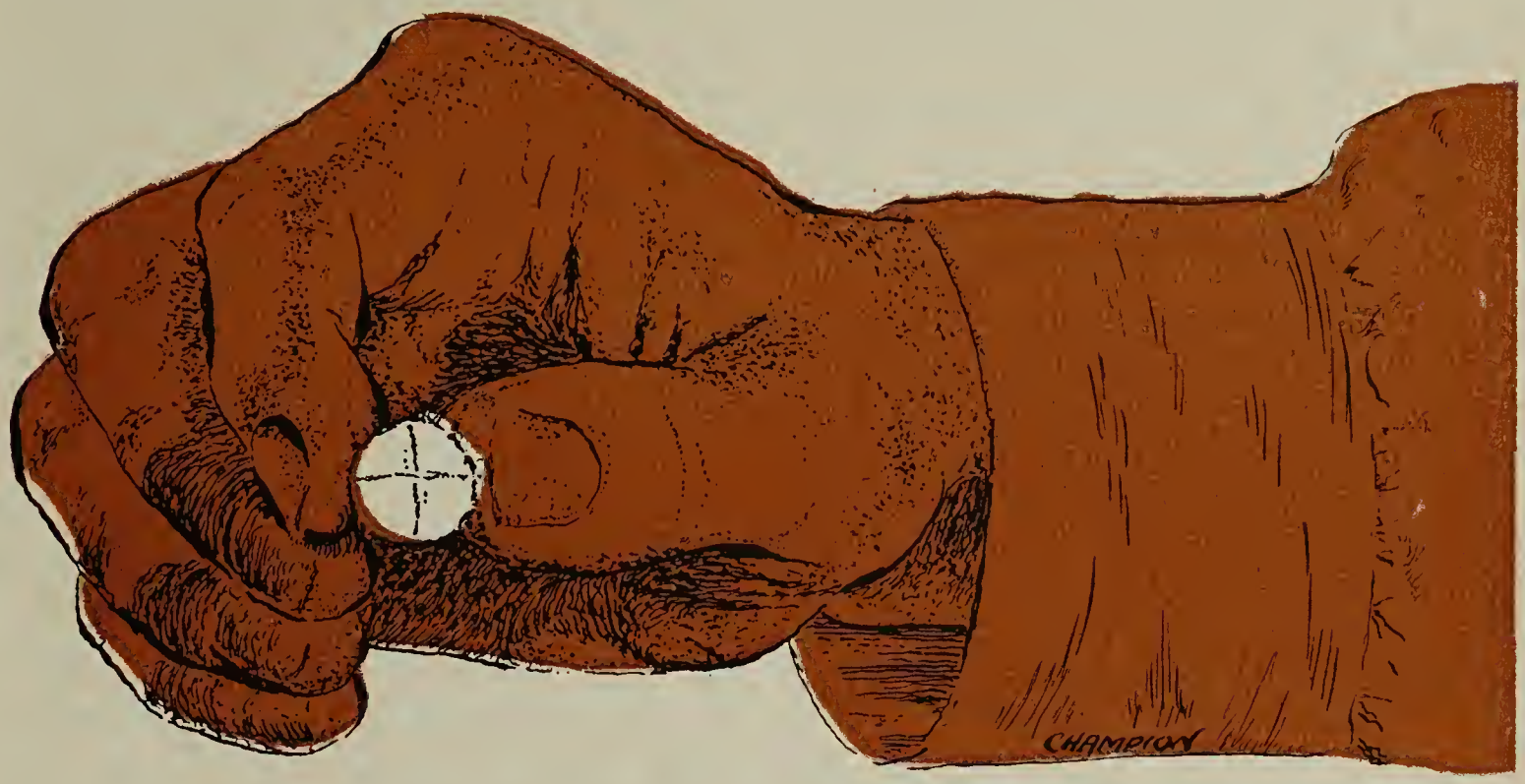
He serves as a liason man between the various services of the big hospital, with the responsibility of see-

(Continued on page 23)

VOL. IV, No. 3 INVENTORY SEPTEMBER, 1954

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

ANTABUSE-



SHORT-CUT TO SOBRIETY?

One thing is for sure: You can't mix alcohol and Antabuse

BY GEORGE ADAMS

MODERN men have come to be great believers in pills and medicines for relieving all sorts of physical ills. We Americans are a nation of pill-takers. We take pills to reduce and pills when we wish to gain. We take them to sleep and we take them to wake up. We gulp them to get rid of headaches, hangovers, and poor appetites. Many of the little medicinal pellets are described as a "sure cure" for everything from ingrown toenails to irregularity. We may suppose that at the present rate, it's just a matter of time before every malady will respond to some kind of pill-cure. There is even a pill for alcoholism.

This anti-alcoholism pill first hit the headlines back in 1951. It went under the jawbreaking name of tetraethylthiuram disulfide, since popularized as *Antabuse*. One of our leading news magazines heralded Antabuse as a "cure for alcoholism." Other popular magazines, through their optimistic and glowing reports of this new drug, created the impression among the public that at long last a simple "cure" for alcoholism had arrived on the scene. The "cure" seemed simple indeed. The fellow

who lost control of his drinking and wished to quit simply started taking Antabuse pills. As long as he took the pills regularly, he *couldn't* drink since alcohol taken into his Antabuse-saturated system would produce violent sickness.

To impress him with just how violent and unpleasant that sickness could be, he was hospitalized and given a test dose or two of alcohol on top of the Antabuse. The result was always the same. Within half an hour, the patient's heart began to skip beats and race wildly, and his breathing became difficult. He became nauseated, his face flushed, and he might even express the feeling that he would die. With the memory of this drastic reaction to prod him, it seemed likely that the alcoholic would shy away from alcohol to avoid such unpleasantness in the future. As long as he took his Antabuse, the patient's sobriety was ensured.

Boosted by publicity in our popular press, Antabuse was received enthusiastically by the public, and particularly by many who had a drinking problem. By building a sort of chemical fence between the problem drinker and alcohol, Antabuse seemed to solve the drinking problem with a minimum of effort and responsibility from the patient himself. An alcoholic is just like the rest of us in that he likes to find a short-cut by which to save time, or money, or effort, or worry, or a number of other things worth saving. Upon first glance, Antabuse seemed to be the alcoholic's short-cut to sobriety.

The drug does have many points in its favor. In pill form, Antabuse is easily taken with a minimum of fuss and bother. The pills can be swallowed regularly as a part of the daily routine, just as insulin is taken by the diabetic. As far as has been determined, Antabuse causes no ill effects in the body so long as no alcohol is mixed with it. Antabuse holds no danger for addiction-prone individuals, since it has been shown to have no habit-forming properties.

Possible Dangers

There are some dangers connected with the use of Antabuse, particularly by those who are not fully informed of its effects. The severe physical reaction produced in combination with alcohol can be extremely dangerous for persons suffering from certain types of physical ailments. Any previous trouble involving heart, kidneys, thyroid, or respiratory tract might rule out Antabuse. For this reason the drug should never be self-administered without a thorough physical examination by a doctor who completely understands Antabuse and its effects. Its continued use, too, should be under the close

(Continued on page 22)

GROWTH THROUGH EXPERIENCE

ALL these things that happen to us aren't good or bad in themselves; it all depends on what we do with them. If they help us to grow in tolerance, or in awareness of new capacities in ourselves, or to see more in reality instead of wishfully; if they help us vanquish some of our closed-mindedness and increase our understanding, then we can be sure that even the bumps will have been worthwhile. No one has yet developed a substitute for experience.

—Camilla M. Anderson, M. D., in *Emotional Hygiene*

A survey of the attitudes and practices of today's temperance leaders indicates new

TRENDS IN TEMPERANCE WORK

BY ALBION ROY KING

This article is condensed from an address by Albion Roy King, delivered before the 1954 session of the Yale Summer School of Alcohol Studies. The author, a psychologist and teacher on the staff of Cornell College in Mount Vernon, Iowa, has for sometime been interested in alcohol studies. His booklet, "Basic Information On Alcohol," published in 1953, has earned a place among the basic literature in the field of alcohol problems.

NATIONAL prohibition was achieved in the second decade of this century by the building of a strong national organization, the Anti-Saloon League of America. Tons of literature were produced and distributed from the headquarters of the League at Westerville, Ohio. There was a gradual decline in the national league during the depression.

After the repeal of the 18th Amendment a reorganization took place in which the national Anti-Saloon League became a clearing house and the burden of activities was put back on the state leagues. Most of these were also in decline, several disappeared, and others went through reorganization.

The Second World War saw a revival in temperance work in nearly every State. The 21st Amendment provided complete state sovereignty in regard to legal controls, the absence of which had been one of the chief reasons for national prohibition. A National Temperance Movement was organized as a result of dissatisfaction in several states with the Anti-Saloon League. After negotiation these were united in 1950 into the present National Temperance Society. Today there are state temperance societies affiliated with the League in 42 states.

Research conducted by the author may indicate some interesting trends and changes in the temperance movement during the past 30 years. An extensive questionnaire was sent to approximately 100 officials and pro-

fessional people who are leaders in the temperance movement in the United State and Canada. The questionnaire was designed to cover three areas: (1) general information about the organization of temperance work; (2) activities of the organizations; (3) concepts which inform the thinking and attitudes of the people working in the temperance movement.

At the time of this writing 61 of the total questionnaires had been returned completed. The majority of the respondents are officially connected with what may be described as the old line temperance organizations. Others completing the questionnaire included church board officials with responsibility for temperance activities, several directors of temperance education groups, and 3 teachers or directors of educational programs in public schools. The organizations represented in the study include 20 which are affiliated with the National Temperance League.

For the most part the temperance movement surveyed is the arm of the dominant Protestant Churches. They carry the load, not only for the inter-denominational temperance organizations, but some of them have very strong temperance board programs within the church.

It must be understood that the material gathered from this study is not adequate for any conclusive statement about the temperance movement as a whole. It may be useful in indicating trends and changes in the movement, and in pointing up current agreements and disagreements among the 61 leaders who are active in 1954. It also suggests the kind of questions and answers which may be useful for further study of the temperance movement.

As an indication of what these temperance workers consider their most important work, they were asked this question: "If your resources in money or in volunteer time were to be doubled, what would you consider the most desirable ways to utilize such assets?" The main responses were as follows: 32, expand education; 8, radio and television work; 7, develop visual aids; 5, add staff workers; 3, organize more legislative effort; 9, expand publications; 4, organize more legislative effort; 4, organize clinics, counselling and rehabilitation facilities.

Constant Controls

Most of the temperance leaders seem to have the conviction that the alcohol beverage industry must be subjected to constant controls and legal pressures. Most activity of this type takes the form of local option work and details in the regulation of the legal outlets. Only 2 expressed opposition to the local option principle. One commented that it seems relatively futile under modern conditions of transportation.

Belief in national prohibition is not dead in the temperance movement, but there is wide disagreement

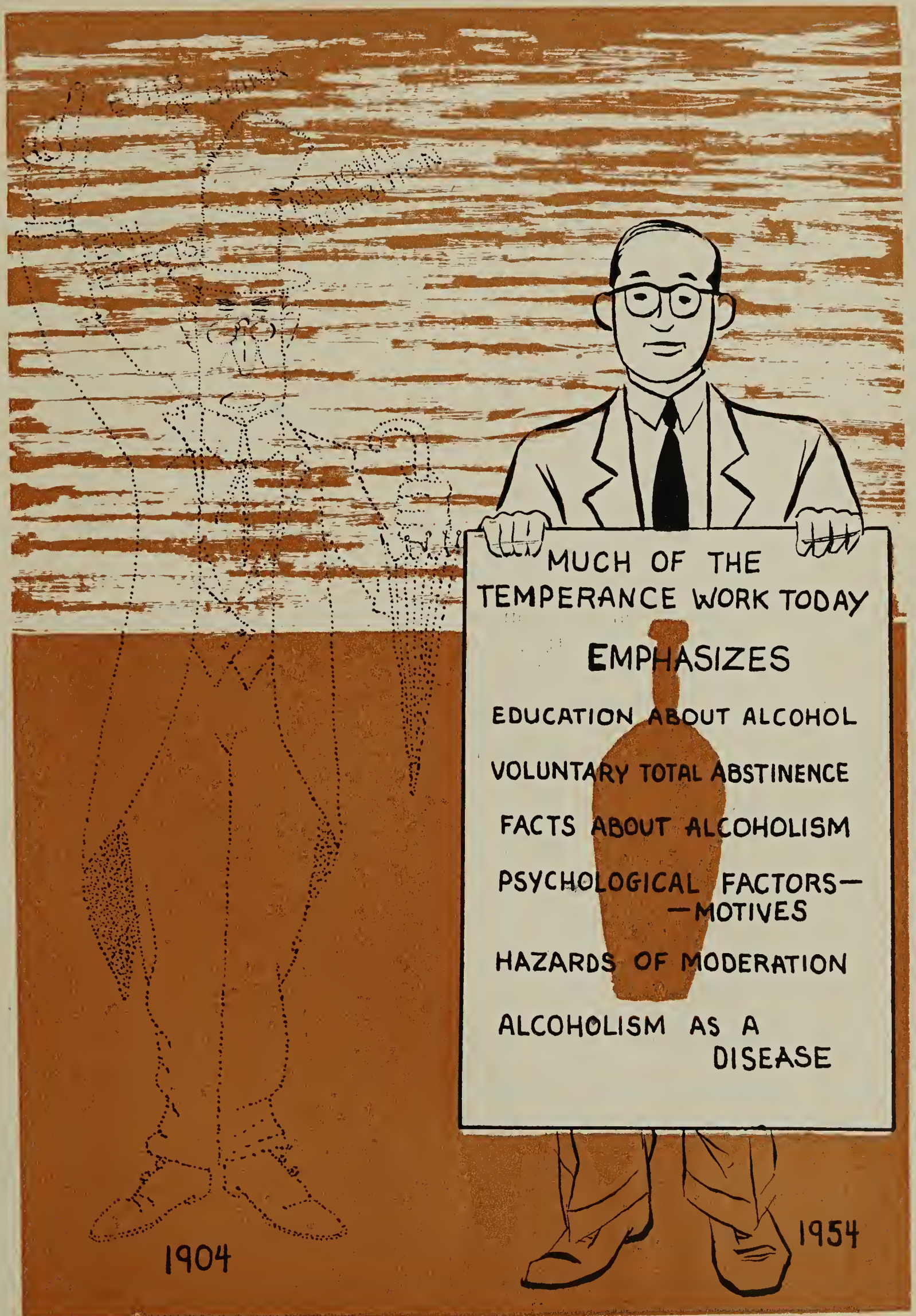
(Continued on page 25)

A MATTER OF SELF-CHOICE

NO man is ever cured of alcoholism by the tears of his wife or the prayers of his mother alone. He must from the bottom of his heart want freedom from his slavery, want it enough to go of his own free choice to those who can help.

—Albion Roy King in *The Psychology of Drunkenness*

A NEW APPROACH TO AN OLD PROBLEM



A social scientist explains twelve important learning experiences which help guide us to

Emotional Maturity

BY NORBERT L. KELLY, Ph.D.

EDUCATION DIRECTOR, NCARP

ALCOHOLISM is defined as one of the stress illnesses. It is an outgrowth of emotional maladjustment. Prevention of the sickness, therefore, is directly related to the development of more emotionally healthy personalities on the part of our citizenry.

But is there a well-defined pathway to better emotional health? At the current state of our knowledge it would be presumptuous and misleading to answer that question in a completely positive manner. By no means do we know all there is to know about human behavior.

Yet the behavioral sciences are arriving at common agreement that certain life experiences seem essential to the development of robust, resilient, durable personalities capable of responding adequately to the tensions in modern American Society. These guideposts to better emotional health are set forth below.

From the discussion it will be evident that emotional health is not a gift from the gods. Nor is it something we inherit. Rather, it is a resultant of a large number of learning experiences which take place while the individual is interacting with other people.

Such experiences begin with the very first days of life and carry through into adulthood. Since the first years are the foundationing period for healthy personality development, we begin there.

Here, then, are what appear to be the important conditions for stability and happiness, for maturity and enjoyment of life—for essential mental health.

Our little human being is born and:

1. *He has a happy babyhood.* He is wanted and accepted by his parents. He is loved and cared for by them. All of his needs are met by them. A baby's life is one of complete dependence. It is a period of receiving, not giving. It is a self-centered life in which the infant is

aware largely of himself only. He is a resilient little fellow and will adjust to change and unlooked for happenings if he has the love and security that come with accepting parents.

2. *He progresses steadily away from dependence toward independence of action.* There is a happy growth into self-confidence through small accomplishments and through doing things for himself. His small efforts are accepted by his understanding parents and he is praised for them. Accomplishment makes him feel important and spurs him on to more complex and difficult achievements. He is becoming an individual, a personality, competent and confident. Independence and self-reliance are developed under the loving protection and watchful guidance of encouraging parents.

3. *He learns to share with others.* Babyhood was a self-centered period. The developing child comes to realize that he is but one among the many. He finds that he has to consider others as he lives from day to day. In some situations he learns that he must cooperate with others to achieve his desired goal. In other situations he must compete against his peers. This induction into the basic social processes is essential to his developing maturity. As an adult much of his behavior will be patterned in the forms of cooperation and competition. If he lacks the ability to use these processes fully he will be at a decided disadvantage in modern American society.

4. *He develops a sense of belongingness.* By being accorded small responsibilities at first, and later on larger duties, he develops a feeling of being an important part of the family group. Apparently this has two significant results. The growing child learns the importance of his actions, his responsibilities, for the welfare of the group. And, in turn, his sense of security as a responsible member of an intimate group is enhanced. His contributions to the

family develop his abilities and his self-esteem. The family protects him and appreciates him for his contributions to its welfare.

(Continued on page 27)

12 EXCUSES FOR GETTING DRUNK

They must be good ones
They've been used by alcoholics
For 2,000 years or more
Without any sign of wearing out
After all, no self-respecting
Alcoholic
Will let himself be caught
Drunk without a "reason"
Will he
It's an old, old story idea
With new words and drawings

By Horace Champion

I OWE EVERYBODY

Sure you do! But did you ever hear of anybody drinking himself out of debt? Figure out what and whom you owe and how much you can pay them each month. Discuss your plan with your creditors—and start paying! Your self-respect will zoom. It **may** work.

IT'S THE ONLY WAY I CAN RELAX

Collapse would be a better word, friend. It's unavoidable in an alcoholic. One drink and you're on your way to another bender. Then you'll be real relaxed . . . on the street, in doorways, the local clink . . . Just don't relax your resistance to suggestion.

I'M OK AS LONG AS I'M ON BEER

Well, good for beer! Only trouble is it gnaws at an alcoholic's weak spots until he switches to something stronger—like sherry. If that doesn't kill you in a day or so, you'll graduate to bourbon. You know how it is. It's not beer, baby—it's only you.

NOBODY UNDERSTANDS ME

The sorry part of this excuse is that you get to believe it yourself. It sounds so convincing. Maybe **self**-understanding is what you need. Run, don't walk, to the nearest treatment center . . . or A.A. Or do you prefer to wind up talking to yourself?

IT'S MY NERVES

You said it, brother! Nobody, but nobody, has nerves so frayed as those of a bottle baby. I wouldn't deny a man a drink, but nerves—that's something else. When liquor is what you need to keep you normal, my friend, you're in sore need of treatment.

IT'S MY MOTHER-IN-LAW

Why, the old hay bag! What a ferocious, meddlesome, insufferable fiend from the pit she is. She's also been your best excuse for over 2,000 years. But give her a chance, son. Don't blame her for sniping. After all, she is somebody's mother.

IT'S HEREDITARY WITH ME

Go ahead, blame it all on great-grandpaw! He can't talk back. He's remembered for the mighty way he held his liquor. But look who's drunk now. Alcoholism is not hereditary. You won't pass it on. You will do it by example.

MY JOB GET'S ME DOWN

Talk straight, mister. You're not getting through to me. Did you say you're getting your job down? Well, that's what you meant. When you start drinking heavily you've changed jobs. The old man in the front office isn't your boss— Alcohol is!

IF YOU WANT TO BE SUCCESSFUL YOU HAVE TO ENTERTAIN

So look at the life of the party. What entertainment this stew will supply will come **after** the party. People will talk about him for months to come. An alcoholic is a big success. He's also a sure thing for the sad-faced man in black.

I'M A VERY SICK MAN

Yessir, the common cold is an alcoholic's best friend (aside from another alcoholic). You're sick all right, Joe, but not with a cold. No germ could last in your gin-soaked system. When you sober up, you'll feel so healthy friends will avoid you. Maybe you need new friends.

I CAN TAKE IT OR LEAVE IT ALONE

Listen, pal, if you were clear-headed enough to have any choice in the matter you'd have no need even to make such a statement. Ever ask yourself why you always decide to take it? It's a bitter pill to take, but an alcoholic must say, "I **can't** leave it alone!" before he can be helped.

IT HELPS ME THINK

Now you're talking! Great thinkers have been great drinkers—but not for long. There are just two ways to be a successful alcoholic: (1) Seek help and recover or (2) hide in the bottle until the old man with the scythe corks it for you. You're not really thinking, pal. You only **think** you think.

WHAT'S **YOUR** EXCUSE?


CHAMPION

Perspective is a skillful tool of the artist,
but there is another—more important—kind of perspective
that all of us must master in the art of living with ourselves.

The Portrait

A SHORT STORY BY HORACE CHAMPION

LET me tell you about a drunk I once knew named Joe . . .the most likeable, hateful, tolerant, critical, shy, aggressive guy you'd ever like to meet or stay away from.

Joe was quite a personality, split cleanly and evenly right down the middle.

I shared an apartment with Joe for a number of years, though the Lord only knows how or why I stuck with him as long as I did. I loved him like a brother, and I hated him like the devil himself.

You may have known someone like that yourself. You know, one of those people you can't seem to break away from. Well . . . Oh, you'd like another drink? Certainly. Will three fingers be enough? Fine.

I walked ahead to the window, pulled the blinds to the ceiling, and stared into the morning sun until the glaring light forced me to turn around and face the portrait.

Joe's idea of a drink was three fingers in a bathtub. Why, I've seen him drink a tea glass full of gin as nonchalantly as you toss off a couple jiggers of bourbon.

He was a real artist, that guy, and not only with the bottle, either. He was a portrait artist when he was sober, which wasn't very often. But even though his sitters never knew whether or not Joe would show up for the appointments he gave them, they always came back, and for a pretty good reason, too. They knew that a portrait by Joe would reflect the sitter's ideal of himself and show nothing of those characteristics which might be interpreted as something less desirable—like greed, selfishness, hate, fear, suspicion.

But if they felt that this was due to Joe's inability to perceive unloveliness, they were naive to say the least. Joe could see only too well the lines of worry and hate, the colors of dissipation and excess, the planes and hollows of guilt and sus-

picion, but he never painted the telltale blemishes of skin and soul that were so clearly etched in their faces.

Joe hated his sitters for their self-deceit, and he hated himself for catering to and perpetuating this false picture of themselves on canvas.

Many's the night I sat with him and a bottle as he paced back and forth before the wet painting on his easel, spitting invectives at the face on the canvas, shouting hate at the quiet likeness, pausing only to pour himself another drink.

"Bah!" he would scream at the unperturbed face, "You would have me believe you are bare of sin and full of character. My picture agrees with you, but I do not! See? I have softened ever so slightly the hard line of selfishness and rejection of humanity in your mouth so that it expresses love and acceptance. I have opened, almost imperceptibly, your narrowed, suspicious eyes and painted therein a look of intelligent interest and trust to further this false ideal of yourself. And I have carefully toned the shadows and lines of dissipation so that they portray a certain distinctiveness and maturity instead.

"That is what you pay me for, is it not? Now I tell you the truth. You are bare of character and full of sin. You are a hypocrite to yourself and to the relatives who will follow you in hanging this picture on their walls. But I am worse than you are because I do not paint you as I see you. I am a hypocrite to Art for the mere sake of your vanity and your purse."

Finally, exhausted and drunk, he would throw himself on the sofa and sleep.

Usually, during an emotional experience of this kind, Joe would continue to drink for several days, ignoring appointments, brooding, occasionally threatening to do the portrait over and paint the sitter as he really saw him.

Whenever he made this threat an odd gleam seemed to appear in his eyes, as if he sadistically anticipated the excitement of carrying out the threat. But then he would sober up, invite the sitter back and finish the portrait in a manner that completely satisfied the sitter's ego, abjectly apologizing for failure to catch all the beauty of expression and depth of character in the living face.

I was always greatly relieved when the portrait was delivered and paid for, but with each new commission Joe's emotional conflict erupted into painful consciousness. One part of him demanded that he continue to paint in the idealistic style to which he was accustomed. The other part of him was equally harsh in its demand that he paint the bad with the good. Alcohol brought the two together in open struggle for domination, and each battle left Joe emotionally and physically exhausted.

I hated to see him in this pitiful state and I used all the reason I was capable of using in a futile at-

IN the advanced stages of (alcohol) addiction . . . hangover is only a brief and very painful state of consciousness separating two periods of stupor.

—Dr. Giorgio Lolli in *Yale Quarterly Journal*

tempt to persuade him to push this absurd obsession out of his mind. But how can you reason with an obsession? All I accomplished was to fan the flames of the conflict.

Perhaps Joe already knew what I was beginning to learn—that he was merely the battlefield on which the final struggle would take place, the battle that would eventually result in victory for one part of Joe and defeat for the other. Possibly Joe himself would be destroyed, but whatever the result we were powerless to control it.

With this realization we waited, avoiding discussion of the matter as much as possible. But the tension mounted, and one evening as Joe was sketching a face on the canvas I had a strange sense of foreboding. I could not concentrate on what I was doing. The skin on my arms and back seemed strangely sensitive.

Suddenly he laughed harshly, as if he did not realize he had laughed, and a shudder rippled up my spine. I knew then that the time had come. Yet I dreaded it, and I made one more final effort to avert what was to happen. I pleaded with him not to destroy himself for the sake of Art, to leave character analysis to the psychiatrists. I even reminded him that painting people as they liked to appear was his bread and butter and alcohol.

He turned on me with the fury of a man gone mad. "You!" he screamed, "You, who stood by me and encouraged me in my work when all others deserted me! You, who shared my good and bad fortunes now tell me that money is all that matters. You tell me to forget principle, to abandon character, to suppress truth and expression, to exploit conceit. "Get out," he yelled, "Leave me alone!"

He swung the bottle in my direction. And then oblivion.

When I awoke the sun was streaming through the window blinds in oblique shafts of piercing light. One was directly in my eyes, and for a moment I did not realize where I was. Cautiously, I raised to one elbow.

I was vaguely aware of objects outlined against the light and in the half-shadows: the one-legged easel with the top-heavy canvas that gave it a weird, unearthly appearance against the slits of light, the uncleaned palette leaning against twisted tubes of uncapped paints, the scattered brushes with their paint-charged bristles, the empty whiskey bottle lying on its side. They were objects, nothing more, and I was somehow detached from it all.

Unsteadily, I got to my feet and rubbed my eyes. Suddenly, the significance of the scene flooded my consciousness and riveted my attention to the dark outline of the easel.

The portrait! The final battle had been fought and the results were painted on the other side of that canvas. All I had to do was take four short steps to see. But the dread of seeing what had been destroyed made them the most difficult steps I had ever tried to take. But take them I must.

When I finally reached the easel I hesitated, but I knew that I could not immediately turn my head to see the portrait. So I walked ahead to the window, pulled the blinds to the ceiling, and stared into the morning sun until the glaring light forced me

He only drinks to calm himself,
His steadiness to improve.
Last night, he got so steady,
He couldn't even move.

—Anon

to turn around and face the portrait.

I see your glass is empty. Let me pour you another drink. There you are. You know, I envy the way you enjoy a drink. Odd, isn't it, how alcohol affects one person one way and another person another way?

The portrait? Oh. Well, for a long time a hundred suns danced between me and the canvas, blurring my vision and making the portrait appear as a meaningless mass of color. Gradually, the colors separated into their proper hues and places, giving life and form to the design. And there before me was Joe's self-portrait.

It was a perfect likeness. I was about to breathe a sigh of relief when something within me urged that I examine the portrait more closely. I squinted at the canvas through nearly closed eyes in order to see the composition and lighting in the simplest forms. The shadows and highlights seemed to be exactly as Joe would have painted them. There were no obvious changes in technique. The colors were a bit bolder, perhaps, but not enough to cause the general feeling of uneasiness creeping over me. Something *was* different about this painting, but what was it? I had to know! At first glance I had been certain that this painting was exactly as Joe would have done it months before. Now I was not so sure.

I stepped closer and critically examined the wet brush strokes. I had seen them hundreds of times before on many of Joe's paintings. I knew them as well as I knew my own handwriting, but the feeling that something was different grew in intensity as I looked. The feeling was one of embarrassment that grew rapidly into revulsion. And then I knew with my mind and my heart what was different. I could *see* it at last.

This painting showed everything that Joe had threatened to paint in others, and more. Joe had consciously and purposely dipped his brush in the lifeblood of his own hate and greed, his fear and anxiety, his selfishness and intolerance, and painted a portrait of himself. It was all there on the canvas. But I had not seen it at first because I had not looked deeply and because Joe had apparently realized that he was not *just* these things, and so he had carefully over-painted this cruel, one-sided picture of himself with the opposing qualities of character that he did possess.

The lines and shadows of hate were lightened by subtle overtones of love. The stark expression of fear in the eyes was toned by a look of self-competence. The selfishness and intolerance that showed in the hard line of the mouth had been tempered with the warmth of understanding.

The uneasy, uncomfortable feeling that I had before I really *saw* the portrait had disappeared, and a newfound calmness seemed to settle over me. I turned and looked through the window at the outside world.

It was a beautiful morning. The park that faced the apartment building shimmered in the clear morning sun. The trees had never looked so fresh and green. People casually strolling through the park never before seemed so attractive and friendly. A young girl, books under one arm, waved gaily to me. And the laughter of unseen children was new music to my ears.

All mornings are beautiful now, especially from my window. Come by to see me the next time you're in my neighborhood and I'll show you what I mean. Where do I stay? Just ask anybody where Joe lives.

—The End

DELIRIUM TREMENS

Fallacy: *Unless they stop drinking, all heavy drinkers eventually develop delirium tremens.* Fact: Less than 5 per cent ever have "DT's." Those who do are usually robust individuals, apparently mentally and physically healthy, who have been drinking distilled spirits steadily and excessively for 8 years or more without obvious ill effects.

Fallacy: *Delirium tremens develops when the alcoholic is suddenly deprived of alcohol.* Fact: DT's usually start *while* the alcoholic is drinking or after a period of several days during which he cannot hold alcohol down because of nausea. There is no reason for the drinker to fear delirium tremens developing as a result of a sudden voluntary or forced withdrawal from alcohol.

Fallacy: *Delirium tremens can be fatal.* Fact: Only rarely is DT's fatal *by itself.* Death occurs because of other diseases or injuries associated with it. DT's often accompanies or follows pneumonia. Failure of an already-weak heart during the violent delirium is another cause of death. Head injuries also rank high on the list. Due to improved treatment methods, the average fatality rate is down to one or two per cent.

Fallacy: *Patients with DT's see pink elephants.* Fact: Patients have all sorts of visual and auditory hallucinations, but they do not include pink elephants. They see dogs, snakes, horses, cats, birds, lions, tigers, whales and even hippotamuses (biting animals). Sometimes they see rooms filled with buttons, zippers, socks or slippers, and tiny men an inch high who joke and play pranks. They may hear bells, beautiful music, or pistol shots.

Fallacy: *A person in DT's is not conscious of what's going on around him.* Fact: Yes he is, too. In spite of his hallucinations, he knows who he is and that he's in bad shape. In many cases he realizes that his hallucinations are not real and may even joke about them. If he harbors resentments and grudges against the "little woman" he will probably tell her off in no uncertain terms if she comes into the room. He is very suggestible, however, and can often be made to read what is suggested to him from a blank sheet of paper.

Fallacy: *Women don't have DT's.* Fact: They do if they drink like their male counterpart of the species. Since fewer cases of DT's show up in women it's simply because there are fewer women than men in the heavy drinker ranks.

Fallacy: *Stick to beer and you'll never have DT's.* Fact: There's a germ of truth here since a person must drink large quantities of alcohol consistently over the years before DT's set in. Beer contains a relatively small percentage of alcohol compared to distilled spirits. Patients with the DT's have *told* their doctors they drank nothing but beer. Well, we don't like to admit some things ourselves, Joe.

Antabuse-Short-cut To Sobriety?

(Continued from page 6)

and prolonged supervision of a physician.

Even these dangers of the new drug did little to dampen enthusiasm over the long-awaited "cure" for alcoholism. But is Antabuse *really* a cure—a short-cut to sobriety?

The Antabuse fence between the compulsive drinker and alcohol, though to outward appearances a sturdy structure, proves to be a frail affair when examined more closely in the light of experience. The point at which the fence is most vulnerable was well stated by one alcoholic who had tried the Antabuse method. "As long as I stay on Antabuse," he said, "I don't drink because I know I can't. But those pills don't cut down on my desire for alcohol. When I can't stand it without a drink any longer, I just leave off the pills." Actually, it is not quite that simple to start drinking again after stopping the Antabuse. The patient must wait at least 72 hours after taking the last pill. This is necessary to allow all the Antabuse to clear the system. Nevertheless, the waiting period will not serve as a serious deterrent to anyone who is compelled to jump off the "water wagon."

Taking pills may temporarily block the alcoholic's symptom, namely his drinking. But they do nothing to relieve the personality problems which produce the drinking symptom. When the patient's emotional pressures build up, and the compulsion to drink becomes unbearable, it is relatively easy to leave off the Antabuse, wait the required time, and resume drinking.

Experience has been that Antabuse therapy by itself is ineffective in maintaining permanent sobriety. Doctors and clinics now using Antabuse in alcoholism treatment are quick to point out that, far from being a "cure," Antabuse is merely a stop-gap measure to enforce sobriety while other therapies are initiated and life-adjustments can be made. Where Antabuse therapy is used at the present time, it is almost without exception strengthened through the use of psychiatry's tool—psychotherapy.

The combination of Antabuse and psychiatric help has a good many advocates today. Some psychiatrists feel that by interrupting the patient's accustomed drinking pattern, Antabuse actually stirs up underlying anxiety and makes the patient more accessible to psychotherapy. Being on Antabuse is thought by some to increase the alcoholic's motivation to seek psychiatric treatment. Others

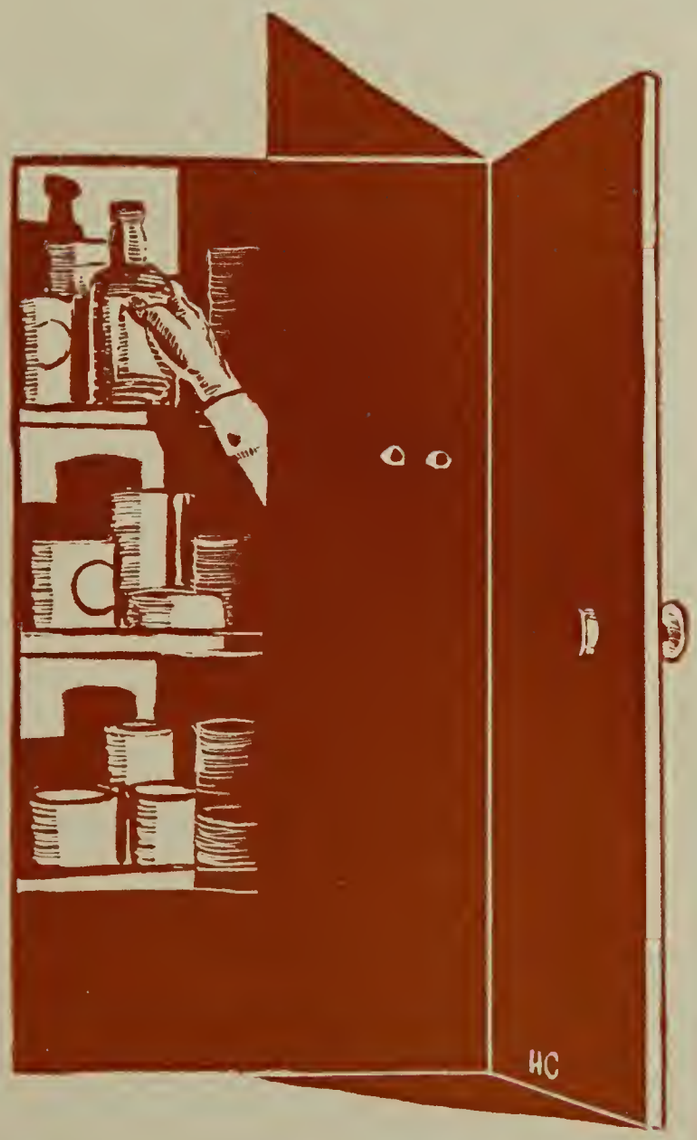
THE little woman went from tavern to tavern looking for husband Herman. Finally she found him seated at a tavern, a tall glass on the bar before him. She sneaked up and sampled the drink.

Making a wry face and dropping the glass she said, "Awful! How can you drink that horrible stuff?"

Herman looked at her sadly. "See? And you thought I was having a good time!"

feel that when a problem drinker seeks treatment voluntarily, that in itself indicates sufficient motivation.

It is obvious, then, that the original claims for Antabuse as a "cure" for alcoholism have been moderated considerably through experience with the drug. It is interesting that the two Danish scientists who accidentally discovered Antabuse's peculiar effects in combination with alcohol never claimed they had a "cure." Nor did other research scientists who experimented further with Antabuse make any such claims. Reports of the "cure-ability" of Antabuse came not from scientists, but from news writers attempting to popularize a technical subject and make an appealing story. Public acceptance of Antabuse as a "cure" for alcoholism arose from our all-too-human willingness to take the first available short-cut around a difficult problem.



Dr. Lorant Forizs, Clinical Director of the NCARP Treatment Center sums up current opinion regarding Antabuse treatment for alcoholism. "It is a chemical fence," he says, "and nothing more. Very useful in some cases, perhaps indispensable, but only for one purpose: to borrow time of sobriety for working out new adjustments; achieving personality changes by psychotherapy, or AA, or any other way. If no new and satisfactory adjustment is worked out under the protective shield of the Antabuse, the patient will undoubtedly fail to maintain his sobriety. He will stop taking the pills and go back to his alcoholic pattern."

Regardless of our wish to have a quick and handy pill cure for the complicated illness of alcoholism, we have found that Antabuse just does not fill the bill. Though it can be useful in an overall treatment program, Antabuse is no short-cut to sobriety.

Personality Sketches

(Continued from page 4)

ing that their work is coordinated for the fullest benefit of the patients. Sometimes legal snarls develop over the admission or discharge of a patient, and Cathell is often called on to straighten out the tangle. Most outgoing correspondence from the hospital staff is routed through Cathell's office. He makes it official by signing his name to each letter.

Administrative details of the NCARP Treatment Center, too, take a goodly portion of Dr. Cathell's desk time. Admission appointments for all applicants to the ARC are arranged through his office, and he keeps a

vigilant eye on the ARC to see that its rules are observed. Since the treatment of alcoholism is a comparatively new field, Cathell feels an obligation to share with others some of the things he has learned about the illness. With this in mind, he recently read before the N. C. Medical Society an original paper on the illness of alcoholism and its relation to other emotional disorders. His colleagues in the Society were so impressed with Cathell's effort they rated it the "best paper," in the psychiatric group, delivered during the session. It has been slated for publication in a coming issue of the N. C. Medical Journal.

The charge is leveled at some administrators that they become bound to their desks and lose touch with the enterprise which they help direct. Cathell is defininitely not vulnerable to this accusation. So far, he has been able to ride his job instead of letting it saddle him, and he manages to keep a finger on the pulse of the entire Butner operation. One of the ways he keeps in touch is by continuing to give a sizeable portion of his time to actual clinical practice within the Hospital and the NCARP Treatment Center. He sees patients of the hospital individually and in group therapy sessions. In addition, he fills his regular turn in conducting group therapy sessions at the ARC, and includes in his schedule a number of private interviews with patients there.

Patients of the hospital and the Alcoholic Center, too, know and like "Dr. Jimmy." They respond to his warm and kindly manner. He is the type of doctor who gives patients the feeling that even when he is behind his desk and up to his ears in paper work, he realizes their problems and has their best interests in mind.

Cathell admits there was a time when he would have scoffed at anyone's suggesting that he might someday be Assistant Superintendent of a mental hospital. "I guess I had a sort of aversion to mental hospitals," he doesn't hesitate to admit, "even though I was a physician." Cathell believes that this attitude was partly due to his own misunderstanding of what a hospital for the treatment of emotional illness is really like. He had always thought of them as places where ill people were confined to prevent damage to themselves and others. Happily, his attitude has done a complete about-face. Coming to Butner in 1947 after giving up a killing private medical practice in Lexington, N. C., Cathell planned to work there only six months while awaiting a position as company physician with a large oil company in the West Indies. When the six months had elapsed, even the lure of the Indies could not take him away from Butner. He accepted a permanent position on the Butner staff, and has been there ever since.

He speaks sincerely of the deep

NCARP BOOK-LOAN SERVICE FOR TEACHERS

DURING the present school year, the ARP is continuing its book-loan service to all high school teachers in the State. Teachers desiring reference works on alcohol and alcoholism for use in classrooms may obtain a kit of the most recent scientific books in this field by writing the Education Director, Box 9118, Raleigh. Each kit is loaned for a one-month period and there is no charge for the service.

satisfactions which come to him as he sees emotionally ill people come to the hospital, receive treatment, and leave well and happy again. The realization that he has had a part in their recovery, says Cathell, provides rewards surpassing anything he has ever experienced, even in his private medical practice.

Distinctive Role

The Butner facility has done a lot of growing since those early days in 1947, and Dr. Cathell has played a distinctive role in that growth. At Dr. Murdoch's request, he set up the initial procedures for administering electric shock therapy and deep insulin therapy, both of which are now regarded as the major treatments for the more serious mental illnesses. Cathell also conducted some group psychotherapy sessions for Butner hospital patients, with such encouraging results that this treatment method is accepted practice at Butner at the present time.

Dr. Cathell, before and since his appointment as Assistant Superintendent of the Butner establishment has an impressive list of accomplishments to his credit. As Dr. Murdoch's strong right arm, he can be counted upon for more of the same quality service in the future.

WRITE FOR NCARP TREATMENT CENTER BROCHURE BOX 9118, RALEIGH, N. C.

Trends In Temperance Work

(Continued from page 8)

on this subject. Only 7 score this point as a primary objective in their organized efforts. Twenty-six believe it could be made to work and that we ought to move into efforts for it. Others say that at best it is a remote goal. All agree that it is not possible nor practical until a vast majority can be brought to total abstinence voluntarily. Twenty-three express definite opposition to national prohibition.

A growing number of leaders are disillusioned with the idea of social reform through legal action. Every form of legal control has been tried, and few leaders are satisfied with the results. The only ultimate Christian solution, they hold, is voluntary total abstinence. This conviction has intensified all efforts at education and commitment through the schools and churches.

Perhaps nothing better illustrates the shift which has taken place in the attitudes and activities of temperance workers than the following scale on which respondents were asked to register such shifts:

35 changed from emphasis on prohibition to emphasis on education.

26 changed from emphasizing the evils of excess to emphasizing the hazards of moderation.

14 changed from emphasis on the evils of drinking to stressing facts about alcoholism.

7 changed in objective from moderation to total abstinence.

2 indicated a shift from damning liquor and stressing its effects to an emphasis on the psychological factors, such as emotion and motives. One noted a change from emphasis

on the right to moderation to emphasis on the social obligations of the Christian.

It is well-known that the temperance movement in the 19th century began with a profound concern for the alcoholic. It was first of all a temperance movement because it sought to reform the drunkard and keep drinkers "temperate." Yet in a historical development, the movement became an effort to achieve total abstinence for the individual and the abolition of the industry from society. Even the Anti-Saloon League was founded at the end of the 19th century in opposition to the saloon, not to alcohol as such, and it received some early support from people in the industry who wanted to abolish that institution.

Problem Obscured

In this development, there is little doubt that the problem of the alcoholic was obscured. The movement objectified its enemy—drink and the liquor traffic—and to some extent lost sight of the fact that individual persons and their situation in existence is the real source of the problem.

A revival of interest in the alcoholic has come . . . since the repeal of prohibition. The stimulus to this interest has not come from within the temperance movement we are reviewing, and the reactions of the temperance leaders to that concern have been mixed.

Forty-three of our respondents agree that alcoholism is a disease. Fifteen deny it. 35 hold that alcohol is the *only* cause of alcoholism, and 21 disagree with that proposition. 34 affirm that alcohol is *only one* of the causes of alcoholism, and 13 disagree with this. The results are not quite consistent, and this certainly reflects the confusion which afflicts our whole understanding of the problem. It is probable that all of those who agree to the concept of disease as applied to alcoholism would insist that the disease notion does not free the individual from moral responsibility.

Helping Alcoholics

Twenty-eight agree with varying degrees of conviction that, "Helping alcoholics to recovery should be a primary concern of temperance work;" 24 disagree. Forty-four hold that, "Helping alcoholics to recovery, while worthy enough for the church or social agencies, is a diversion from the main objectives of the temperance worker." Thirteen disagreed with this statement. As noted above, 5 of the organizations surveyed have departments devoted to counselling and rehabilitation.

What the temperance organizations are actually doing in the area of counselling and rehabilitation is the more decisive consideration. It seems very definitely that there is a trend toward more active participation in these functions.

Five leaders list a "Counselling service for alcoholics" as a major ac-

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Patient in the Clinic: I've been drinking and my conscience is troubling me.

Doctor: I see, and since I am a psychiatrist, you want something to strengthen your will power?

Patient: No, something to weaken my conscience.

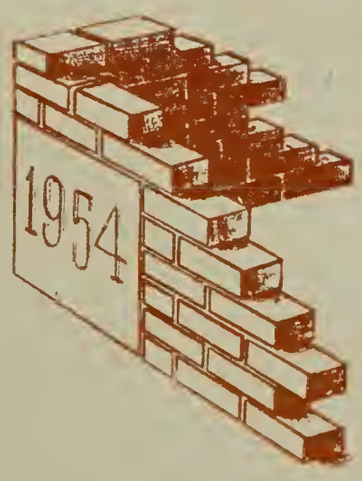
tivity of their organizations. Two of these are state organizations affiliated with the National Temperance League; 2 are church organizations and one is a Canadian provincial organization. Five others regard this as a secondary function, and 15 check it as a desirable activity but not accompanied by much action. Five registered indifference and 9 listed it as irrelevant to their program.

Thirty-four actively support Alcoholics Anonymous. Only 3 register opposition to AA; 4 indifference, and 3 irrelevance.

In 3 states at least the temperance league organizations have been active in securing clinical and hospital facilities for alcoholics. Twenty-four register approval of such a project. One registers opposition to the idea; 4 indifference, and 8 list it as irrelevent.

Several of the state organizations are active in the committees on alcoholism, and one has an active program of industrial rehabilitation which takes the time of one man.

This area of counselling and rehabilitation is a growing concern of the temperance movement, but it is also evident in the current attitudes of the leaders that the movement is not to be diverted from what it conceives to be its more important function, the prevention of alcoholism.



Emotional Maturity

(Continued from page 11)

5. *He learns to accept frustrations.* As he matures, the mentally healthy child learns that life-experiences are a delicate balance of success and failure. Sometimes he comes out on top. Sometimes he fails. For his mental well-being, the successes must outweigh the failures. Parental understanding and guidance must help him hurdle the disappointments and spur him on to new achievements. Frustrations in small doses, however,

are essential to the developing personality. They act as an immunization toward the larger and more important frustrations which inevitably will be the individual's lot as an adult. The manner in which he learns to adjust to disappointment as a child will govern his reactions to such problems in maturity.

6. *He develops the ability to make friends.* In the process of growing out of the family and into the larger world, the individual comes to value the friendship of persons of both sexes. He finds that by giving of himself, through sympathy, understanding, common interests, and mutual aid, he develops relationships with others that result in personal satisfactions and feelings of security. He develops a healthy interest in the

opposite sex which eventually grows toward courtship.

7. *He learns to understand himself and his society.* With today's world as complicated as it is, it is essential that the maturing individual become thoroughly acquainted with the demands his society places upon him. He must understand also the inner working of his own personality. And he must know the relationship between self and society. Adequate study, therefore, of personality development and cultural pressures is mandatory. A knowledge of mental health principles and practices as they apply in our society is invaluable.

8. *He acquires social and avocational skills.* The importance of good-grooming, politeness, and of helping others is learned. The maturing individual finds satisfaction in developing the social graces—interesting conversation, dancing, etiquette. He acquires interests in hobbies and sports that will help him achieve the attention and approval we all need. And he does not neglect his physical health. He learns the symptoms of the common physical illnesses and consults a doctor when necessary. He follows a regimen of adequate diet and exercise.

9. *He plans for the future.* As he is growing up, the emotionally healthy person canvasses job possibilities. He decides upon and prepares himself for an occupation that will both interest and reward him. He may wisely seek the help of parents and vocational counsellor in this matter. As he is approaching adulthood, he begins to narrow his love-interest. In high school or in college he will take advantage of the marriage and family courses which are offered to young people today, the better to prepare them for this important life-step.

10. *He selects a compatible mate.* The spouse chosen will be warm, sympathetic, and understanding. Her emotional maturity will match his own. She will be cooperative and helpful, but able to exist as an independent personality. Together, before marriage, they will consult a marriage counsellor and become thoroughly acquainted with the responsibilities of marriage and family living. They will gain a knowledge of their collective strengths and weaknesses and begin marital life in a positive way.

11. *They live a full life.* He is now one of an inseparable pair. What he does, how he acts, what he thinks will always be colored by this new social state. Together man and wife must use all their potential for the good and interesting life. Their major interest, of course, will be the family they raise. The knowledge of themselves, their personality development and their society they developed earlier in life will be of inestimable value here. But they will not con-

fine themselves to family boundaries. Interest in sports and hobbies will continue. These are excellent antidotes to family tensions, thwarted ambitions, and other frustrations. Religion, participation in community affairs, interest in world affairs, travel, all add breadth and fullness and meaning to living. Children, jobs, creative avocations, active recreation, and community affairs will add up to an enriched, dynamic life.

12. *They live by the Golden Rule and the Golden Mean.* In great measure we get from life in proportion to what we give. We receive from others in kind. In the final analysis, man's behavior is foundationed in morality. If one is to have his basic needs met through interaction with others, in turn he must help meet theirs through kindness, affection, justice, and understanding. Life, too, must be in equilibrium. There must be a balance among work and play and rest. One aspect of living must not be exaggerated or overemphasized to the detriment of the others. Emotional maturity is a reflection of the harmony one achieves among life's interrelated areas.

Program Pointers

(Continued from page 3)

gone into the production of our film. We are grateful to all those persons in Chapel Hill who are working so tirelessly to give us a moving picture of which we can all be proud.

At this writing, filming is being completed. There remains the tedious task of editing, synchronizing the sound, and putting together snatches of scenes into a smooth-flowing and meaningful sequence.

This motion picture, when completed, will be unique in the field of alcoholism education. It is being made especially for telecasting over the State's television stations. The movie will also be suitable for showing before a variety of church, community, and civic groups throughout North Carolina. Upon completion, announcement of its availability will be made through INVENTORY. We hope that "Domino" will enjoy wide circulation, and that it will promote a greater understanding of the illness of alcoholism among our people.

NEW LOCATION FOR NCARP OFFICES

THE offices of the N. C. Alcoholic Rehabilitation Program have recently been moved from the Agriculture Building to spacious new quarters at 15 West Jones Street in Raleigh. Our new offices are located in a former residence recently purchased by the State and renovated throughout. The new location provides us with some much-needed additional space for offices and storage and the entire staff is pleased with the change. We are grateful to the Board of Buildings and Grounds for providing us with such attractive and adequate quarters, and we invite our friends over the State to visit us.

The ARP mailing address remains the same—P. O. Box 9118, Raleigh.

EYE OPENERS

Capsule information

and comment

Don't blame your glands if you're overweight, advises Victoria Hathaway, R. N., in an article appearing in TODAY'S HEALTH. If you're fat, you're eating too much, she says, and she points out that psychologists now recognize that people who keep up an excessive food intake are usually satisfying some basic fundamental need by over-eating — the same sort of needs that lead other people to drink excessively. She states overeating and excessive drinking are now known to be symptoms of underlying emotional disturbance.

•

Another item from TODAY'S HEALTH interested us, and we want to pass it along to you. It points out that the neurotic person usually knows that something should be changed to make him feel better, but he almost always tries to change something in his life environment—his job, his home, his spouse—rather than something in himself. It advises physicians to beware of becoming easily convinced that outward changes would be the answer to the neurotic's problems.

•

According to the 1954 AA Directory there are now in existence 5,401 AA groups throughout the world with a combined membership of 128,296. The *Grapevine* reports that 435 new groups were formed in 1953, better than one a day! California has the largest membership — 11,020 — and New York runs second with 7,223. North Carolina is reported to have 1,884 members.

•

Statistics compiled by Mark Keller of the Yale School of Alcohol Studies show that the number of alcoholics in the United States increased from 2,632,00 in 1940 to 3,852,000 in 1949, representing an increase of 46 per cent. The rate of alcoholism per 100,000 adults in this country shows an increase of 30 per cent during the same period of time; while, surprisingly, the alcoholism rate per 100,000 actual drinkers has increased by only one per cent.

•

Reports from Federal, State, and local officials show that between 1946 and 1953 these agents acting independently of each other, seized more than 20,000 illegal stills each year. This is a rate of violations comparable to the prohibition era when 22,000 to 25,000 seizures were reported each year.

•

Rev. Ernest Shepherd, Administrator of the Florida Program on Alcoholism, gives us some interesting information regarding the positions of the 29 major religious bodies in the U. S. and Canada on alcohol problems. Shepherd found that 10 of the 29 major religious groups urge voluntary abstinence for their members, while 8 currently require total abstinence for membership. Only one church group — the Evangelical United Brethren—currently takes a stand in favor of national prohibition.

NEW PUBLICATIONS

OF THE N. C. ALCOHOLIC REHABILITATION PROGRAM

FREE FOR THE ASKING

THE NEW CORNERSTONES, a basic manual on alcohol and alcoholism, is now available. Written in straightforward, simple language, this comprehensive booklet should prove helpful to both the layman and the professional worker who wishes to gain a better understanding of the background and development of alcohol problems. Some of the chapter titles include: Social Drinking and Alcoholism, Facts About Alcohol, Alcohol and the Human Body, Why People Drink, How to Help an Alcoholic, and Treatment for Alcoholism.

NCARP TREATMENT CENTER BROCHURE, through word descriptions and photographs, explains what the patient can expect during his 28-day stay at the NCARP Treatment Center—including treatment methods, recreation, diet, entrance requirements, rules and regulations, and daily schedule. This publication should be of interest to prospective patients, and to ministers, social workers, physicians, nurses, and others who come into contact with problem drinkers who need help.

ARP RESEARCH PROJECT NO. 3, entitled Alcoholism and Social Experience, is the result of research by Dr. Norbert Kelly into the social histories of 250 anonymous former patients of the NCARP Treatment Center. Included in Dr. Kelly's investigation are family influences—both parental and marital, employment situation, education, religion, and recreation. Only a limited number of these studies is available and only requests from professional people—ministers, social workers, sociologists, physicians, clinical psychologists—can be honored at this time.

WRITE OR SEND THIS COUPON TODAY FOR YOUR COPIES

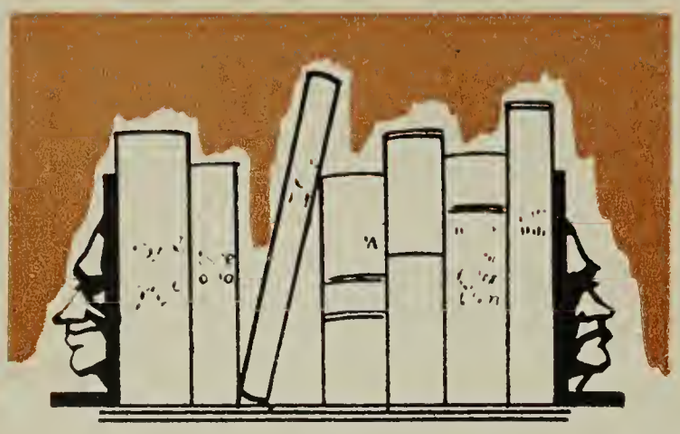
N. C. ALCOHOLIC REHABILITATION PROGRAM
P. O. BOX 9118, RALEIGH, N. C.

Please send me the following literature:

☐ THE NEW CORNERSTONES
☐ THE ARC BROCHURE
☐ ARP RESEARCH PROJECT NO. 3

Name: _____
Street Address: _____
City & State: _____

☐ Please place my name on the mailing list for INVENTORY magazine



Books of Interest

THIS IS NORMAN BROKENSHIRE

$3.50

An Unvarnished Self-Portrait
by Norman Brokenshire
New York: David McKay Co., Inc.

THE standby signal is on. Slowly the minute hand of the big studio clock sweeps toward the hour. Millions of fans await the opening music and the famous voice of one of the greatest announcers of the day, Norman Brokenshire. But the nationally recognized "How do you do, ladies and gentlemen, how *do* you do," never comes. In its place is heard the more prosaic greeting of a replacement. Brokenshire is off on another drunk.

How many times this disheartening scene was enacted I suppose not even Brokenshire remembers. Happily it is now a thing of the past. "Broke" is an alcoholic. But his alcoholism is under control. He's been dry for years and back at the top of his profession—to stay, we sincerely hope.

At times this story is so moving and poignant it becomes almost unbearable to the reader. He finds himself torn with pity for the poor, sick devil who is being inexorably destroyed by his illness. Time after time I found myself groaning, "No, no, not again!" as success and fame are dashed from Brokenshire's hands and he is left in abject despair—jobless, homeless, wretched.

The author is unsparing in the details of his early life. This is significant, for apparently the emotional maladjustment at the base of his alcoholism was set in his childhood.

A happy, contented adulthood is almost unthinkable without a happy childhood. Norman's early years were full of fears and anxieties engendered within family relationships. Frequently he was set adrift by his parents to more or less care for himself. At other times he was under the rigid domination of his father, a minister, whose restrictions he detested and whom he feared.

From a frightened child, Norman Brokenshire grew up to be an insecure, apprehensive man who found escape from his anxieties in the anesthetic properties of beverage alcohol.

He tried mightily to overcome his addiction to alcohol. At one time he underwent the "sugar cure," with little success. Private sanitoria, the Peabody Method, aversion treatment each gave surcease for relatively brief periods. But it wasn't until he actively tried Alcoholics Anonymous that he found the answer to his particular problem.

Along with his personal story, Brokenshire gives the readers a behind-the-scenes history of the development of radio, in which he was one of the pioneers. He graphically describes the improvisations of the early days, the tenseness, the man-killing pace of this developing giant.

But these are sidelights. This is a gripping account of a long struggle with a terrible illness.

—Norbert L. Kelly, Ph.D.

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
415 Halifax St.
RALEIGH, N. C.
Phone: 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: 3-8343
Monday through Friday

Mental Hygiene Clinic
210 N. Greene St.
GREENSBORO, N. C.
Phone: 3-9426
Also at HIGH POINT
Phone: 8929
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
Chapel Hill, N. C.
Phone 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: 3-5441 & 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: 3-2471, Ext. 29
Monday through Friday

Graylyn Hospital
WINSTON-SALEM, N C.
Phone: 3-7391

FRIDAY ONLY. This is purely a Clinic for alcoholics and their families. Out - patient mental hygiene clinic is located at Baptist Hospital, Winston-Salem.

Toward helping patients to re-establish satisfactory social relations all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly journal using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The Butner Brochure—illustrated 36-page book on North Carolina's program of treating alcoholism as an emotional sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

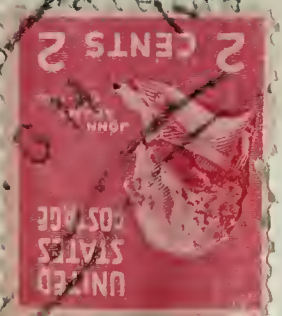
Library Kits—kits containing books and pamphlets on alcoholism. Available to libraries from N. C. Library Commission, State Library, Raleigh.

Book Loan Service—kit of reference works on alcohol and alcoholism, for high schools. Order from Education Director, Box 9118, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
Box 9118
Raleigh, N. C.



Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

NOVEMBER, 1954

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

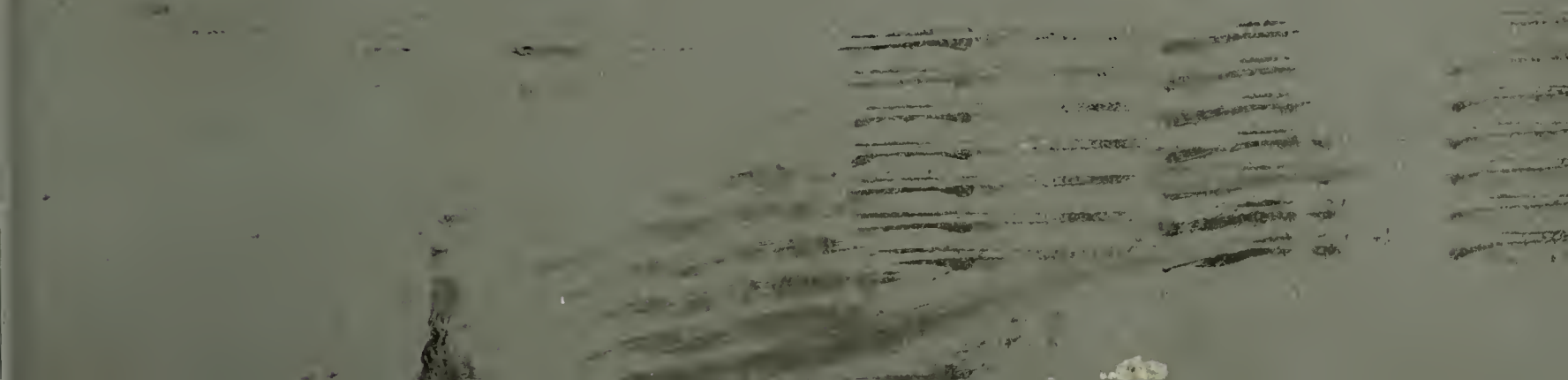
PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION



N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $72 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, a social worker, a recreation director, and occupational therapist, and ten attendants.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.
2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.

3. A fee of $72, in cash or certified check, must be paid upon admission.
4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illnesses. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
8 A.M. to 11 A.M. Saturday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

S. K. PROCTOR
Executive Director

NORBERT L. KELLY, Ph.D.
Educational Director

LORANT FORIZS, M.D.
Clinical Director

INVENTORY

VOLUME IV — NUMBER 4
NOVEMBER, 1954
RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices, 15 West Jones St., Raleigh, North Carolina.

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Circulation This Issue: 16,500.

This journal is printed as a public information service. Persons desiring a place on the free mailing list must send in a written request. This journal will not be sent to persons other than those requesting it.

Write: INVENTORY, 15 W. Jones Street, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

Likes New Brochure

You are certainly to be congratulated upon the new pamphlet and brochure regarding the Alcoholic Rehabilitation Center at Butner. The Brochure, I feel, is particularly well written and illustrated. As you may know, Miss Brooks recently sent us a large allotment of these as we have been having many requests for them.

Ruth W. Haun, Coordinator
Forsyth County Program on Alcoholism

Informative And Useful

This Division Office has been receiving a copy of your publication regularly and find it to be quite informative and most useful. We feel that it would be very valuable to have it available for all units of our staff. We would appreciate it if you would kindly place the enclosed list of headquarters offices on your mailing list to receive this publication regularly in addition to this office.

Earl F. Hoerner, M.D.
Director,
Division of Alcoholic Studies
State of Pennsylvania

Inventory Sheds Light

This is just a short note to tell you how very much I enjoy and profit by your terrific magazine, INVENTORY. Your magazine is a little candle in an area of darkness. May it continue to glow and warm the hearts of suffering alcoholics and their families—everywhere. It has touched mine.

Mary M.
Palisades Park, N. J.

Praise For Kelly Talk

Dear Dr. Kelly:

Enclosed herewith is a copy of the write-up of your talk to the Kiwanis Club as it appeared in the local daily newspaper. I served as program director for our local Kiwanis Club during the first quarter, and I heard many compliments and much praise of your talk.

It was well taken and well worth while; I just hope we can get many of the civic organizations of the State to put on similar programs (on alcoholism) at least once a year.

John M. Jackson
Gastonia, N. C.

ARC "Graduates" In AA

We wish to express our gratitude and appreciation for the wonderful job you are doing. The INVENTORY gets better with each issue. We all wish it were published each month. We are using many of your articles for programs. We recently had a "Butner Program," had a "graduate" as principal speaker, followed by open discussion. This included treatment, food, amusement and follow-up program. It was one of the best meetings we have ever had and we believe every AA group would benefit by doing the same.

Gertrude K.
New Bern, N. C.

Program Pointers

By S. K. Proctor

EXECUTIVE DIRECTOR

AS this issue of *Inventory* goes to press I am preparing to leave for Madison, Wisconsin, to attend the fifth annual meeting of the National States' Conference on Alcoholism, which I am privileged to serve as Secretary-Treasurer.

This annual conference is important in several respects. First, it brings together the administrators and many of the clinical personnel of the various State Programs on alcoholism to compare notes on their activities in the field and exchange ideas which can benefit them all. Many of the leading professionals in the field of alcoholism will speak at this conference on program organization, research, policies, methods, etc.

North Carolina takes an exceptionally active part in the National States' Conference this year. Dr. Lorant Forizs, our Clinical Director, is a member of the Research Committee. Dr. Norbert Kelly, our Educational Director, serves as chairman of the Standards and Program Evaluation Committee, and will make a report of a survey of organization and treatment policies of State sponsored alcoholism programs. And our Psychiatric Social Work Consultant, Miss Roberta Lytle, will also present a paper on treatment goals for the alcoholic patient.

In addition to providing a medium for the exchange of ideas and information, the National States' Conference serves as a sounding board for its various committees on alcohol problems. One of these is studying the possibility of establishing standards for the classification of problem drinkers. Another has been looking into the educational, clinical and related services of established programs for the guidance of states about to enter the field of alcoholism and for the self-evaluation of states already administering such programs.

Pre-conference correspondence indicates that other matters pertaining to public education and information will be discussed and possibly acted upon.

State Programs

Twenty-seven states now have programs on alcoholism, and I feel sure that all of them will be represented at the conference in addition to a number of other states contemplating such programs. Canada also will be well represented there.

State-sponsored programs on alcoholism are relatively new, and the National States' Conference is even more recent, having been organized just five years ago. But the fact that the States are getting together, pooling their experience and knowledge, and carrying on the fight against alcoholism individually and collectively, is an indication of the determination of the American public to do something about a problem that has been left unsolved too long.

Personality Sketches

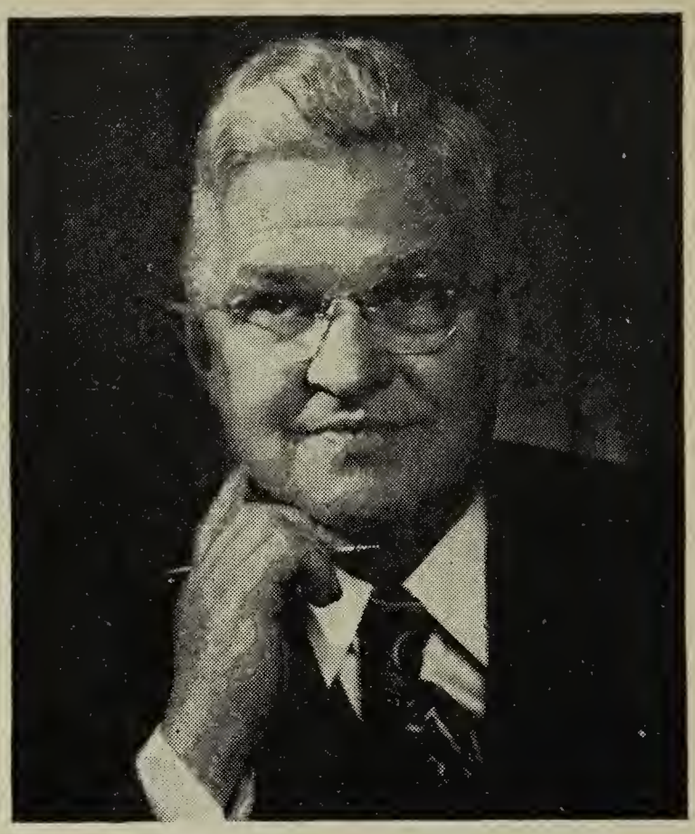


Photo copyright by Robert L. Shoaf

JOHN S. RUGGLES

Chairman

ARP Committee of the Hospitals

Board of Control

ONE Spring morning in 1949, North Carolina legislators filed into their places in the Senate and House to find something of more than usual interest. On each desk lay copies of a newspaper article and editorial, both making an eloquent and dramatic plea for passage of an Act providing for the care and treatment of alcoholics. Dateline of the reprinted article read *The Pilot,* Southern Pines, N. C., April 1, 1949. Moving force behind its distribution, along with a number of other schemes to stir up support for the Alcoholic Act, then crammed hopelessly into a committee pigeonhole, was a *Pilot* subscriber and Southern Pines resident—John S. Ruggles.

A private citizen and prominent Sandhills businessman and civic leader, John Ruggles was among the original group of persons to become interested in a State-sponsored Alcoholic Program for North Carolina. His efforts in conjunction with those of Representatives Umstead, Blue, and Kilpatrick were largely responsible for dislodging the Alcoholic Rehabilitation Act from committee and securing its passage in the 1949 General Assembly.

But with passage of the Act, Mr. Ruggles' work, he found, had just begun. In recognition of his efforts, Governor Scott promptly appointed him to the newly-reorganized Hospitals Board of Control, and he was subsequently appointed Chairman of the Alcoholic Committee within that body—a position he still holds. Thus he found himself with the responsibility of drawing up concrete plans and getting into operation what was still a "paper" program on alcoholism, subject, of course, to the approval of the Hospitals Board.

Mr. Ruggles admits that when he first surveyed his task he optimistically failed to reckon with all the complicated aspects of the problems of alcoholism which would have to be faced and dealt with. "With the prospect of $300,000 to spend," he admits, "I could see no reason why we

(Continued on page 32)

VOL. IV, NO. 4 NOVEMBER, 1954

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

ALCOHOLISM- A Spiritual Problem

BY RT. REV. RICHARD S. EMRICH
BISHOP OF MICHIGAN

Condensed from an address given at the Annual Meeting of the National Committee on Alcoholism

SINCE man is a complex being, alcoholism, in its prevention and cure is a complex problem. Man is a physical being and therefore alcoholism concerns the doctor. Alcoholism can be caused by physical sickness and it results in physical sickness. Man is also a psychological being and therefore the psychiatrist is concerned. Alcoholism is an escape from reality caused by loneliness, anxiety, insecurity, disappointment and hostility. Man is a social being, and therefore we are all concerned, because this is the fourth largest social-health problem of our nation, with its effect upon our economic life, our traffic problems and our homes.

But man is also a spiritual and religious being, and since it is good for each of us in humility to stick to

his own last and recognize the great contribution of others in a complex problem, I am writing as a clergyman.

That alcoholism is a spiritual problem is proved by the fact that Alcoholics Anonymous, a spiritual movement, has had considerable success in dealing with it. Alcoholics Anonymous is a spiritual movement, a way of life that continues for its members over the years. Now, in the good life from the spiritual approach there are two problems. The first is the knowledge of what is good, for how can a man live a good life if he does not know what it is? The second problem of the good life is the power to do the good once you know it. At a superficial level of life the knowledge of what is good is sufficient to enable us to do it, but at the deeper levels of life the all-important question is moral power. Moralizing is not only futile; it is also irritating when you confront the deep levels of life. How silly it is to say to a person gripped by anxiety that he ought not to worry, that it's not good to worry. So it is with the alcoholic. Don't just moralize with him—*get some information.*

Deep Levels Of Life

He illustrates that there are deep levels of life which ordinary motivation does not reach. He knows better than we do the reasons for not drinking. His problem is moral power, the power to do the good. He is a compulsive drinker who does not go through those agonies because he wants to. He needs help from beyond himself, moral power as all men need it, and that of course is what Christianity promises.

I've forgotten where I read it, but it's a true saying and I have it written in the back of my Prayer Book: "The road to perfection is through a series of disgusts." We must, with some flash of insight, see ourselves as we are, come to ourselves, be honest, and see ourselves as we really are. Since man is a spiritual being, he must want in some manner to be different than he is before he can walk the road to recovery. In this way the alcoholic must walk the road that every man walks. If closed in on himself, he thinks that he's all right and the world all wrong; if in bitterness he blames outside circumstances, then he cannot be helped.

Alcoholics Aren't Different

Alcoholics are not the only people who come to themselves when they "hit bottom." The great grace of all suffering is that we do not cut a good figure in our eyes when we really suffer. I say this because I do not want anyone to think that an alcoholic lives in another spiritual world, or that we are dealing with strange and different people. No man who is satisfied with himself can grow, and we must turn outside of ourselves for information and for help.

So a broken man, a man who has died a death, comes to a group, comes for help from outside himself, goes to the clinic, writes for information. We are dealing with men and women, not robots, and this is a spiritual problem. And that means that in spite of all the hope offered, there remains the possibility of complete failure. *The road to perfection is through a series of disgusts.*

My second point is fellowship and the need for forgiveness. Let's look at this word, "forgiveness," because many people misunderstand it. Forgiveness means acceptance. If you're not forgiven, you're shut out. When you were forgiven as a child by your parents, you were accepted by them. We need to be accepted and loved. We need to belong. You can be cured, I guess, of appendicitis without love and acceptance, but you cannot be

cured of any mental ill without love and acceptance and it's here that the clinics and other healing groups show their strength.

If a man is an alcoholic, the thing he most desperately needs is fellowship and acceptance. In Alcoholics Anonymous, for example, hands are reached out to him; he's accepted and wanted and brought to a body that knows his problems, talks his language and offers him hope. He's not condemned or ostracized. And don't you condemn or ostracize, because that is the way to ruin a man.

Need For Fellowship

There's nothing strange or unusual in this need for fellowship. When we belong one to another and are accepted and share deeply together, it is true that power comes to us which cannot come when we are alone. Loneliness is for all men, hell. Fellowship gives life, ability, and strength to people and there is no substitute for it. An alcoholic can't get along alone any more than anyone else can. Man is a social being who comes to himself in his relationships with others and in Alcoholics Anonymous for example, they share together, pray together, come to a deeper knowledge of themselves, and they are encouraged by the triumphs of others. There's nothing unusual about this. Men, who by themselves would be cowards, can be heroes in the fellowship of a regiment. We can say, indeed, that apart from fellowship there is no salvation for an alcoholic.

Three. I don't need to tell you of the thousand places in religious literature where help from beyond ourselves is proclaimed; and I want you all to turn to the spiritual resources of your community. "They that wait upon the Lord shall renew their strength." It's a fact of life that we live upon the world beyond us. If we close ourselves in, we perish.

Physically, we stuff food from the outside into our mouths. We breathe air from the outside into our lungs. We feed our minds and grow by looking at the world outside us. We're not meant to close ourselves in but to open ourselves, and so it is with the life of the spirit. The tragedy of much of the modern world is that men have closed themselves in as far as their souls are concerned. This, very simply, is what the Church to which I belong means by sin.

Sin in a big sense is not an act. It's a state of separation and isolation from God. It's a lone relationship, living with one's back to God, closed in on one's self. This means that the fundamental error of the world is prayerlessness or Godlessness, the fundamental error for all men, including the alcoholic. We sever ourselves from the fundamental relationships for which we were intended and live without the power and friendship of the greatest Friend that man has. And then there comes a crisis in the self-enclosed life, the failure of our proud independence, and we open ourselves and ask for help.

A Conversion

Now a good many groups are built on the fact that this turning to God, this turning to a Higher Power, this opening of ourselves, is the secret of recovery. Actually, it's a conversion. In Detroit we're not afraid of the word "conversion," for we have converted factories from peace-time to war-time use, and we have converted them back again. Conversion means a change-over, a shifting of goals, a change of direction. So a man for example who has lived for himself, turned in on himself, opens himself and begins to feed on that beyond himself as every child of God is meant to do. And this is the source

of his strength. This is true in Alcoholics Anonymous and this is true in the Church, and no person can rise to a new life without it.

My fourth point is service. And here once again a group like Alcoholics Anonymous has touched the secret of power. It's a group with a saving zeal, and may it always have saving zeal! It's not an intellectual movement or discussion group. It bears salvation, and this means that its members have to go to work.

Now the power that comes can be explained in that having been dry for a while, with the hope of life in him, a man picks up another man and sees in vivid contrast that condition from which he has been lifted. Let's put this another way, for it can apply to all of us. Power does not come to people who do not venture out to God. He sends his power and joy and peace to those who fight his battles.

Service, then, is not just a revelation of the new attitude in a man, of a new life moving through him. It is also an actual channel by which new life comes to him. We give of ourselves because we are, we hope, new people. But we also become new people by giving of ourselves, and one of the great truths of life for all of us is that when we venture out on new and trembling legs, we are strengthened to do things we never dreamed we could do.

FOOTNOTE ABOUT THIS ISSUE

READERS will note that this issue of *Inventory* consists almost entirely of talks given before the annual meeting of the National Committee on Alcoholism last March. The Executive Director of the NCARP and your Editor attended that excellent meeting and were greatly impressed both with the theme of the day's proceedings—which was a vivid description from beginning to end of treatment for the alcoholic—and with the highly interesting content of the talks.

Your editors feel certain that you, too, will enjoy reading several of the condensed versions, and they offer them to you with apologies for being unable to reprint them in their entirety due to space limitations of *Inventory*. For this reason also, other interesting talks that made up that day's program do not appear here. However, the reader's attention is invited to the fact that transcripts of all the talks as they were given can be purchased for a small charge from the National Committee on Alcoholism. If interested, write to: The National Committee on Alcoholism, Academy of Medicine Building, 2 East 103rd Street, New York 29, New York.

Tact, understanding, and a willingness to listen are effective tools in working with the alcoholic patient.

THE ALCOHOLIC IN THE DOCTOR'S OFFICE

BY HAROLD W. LOVELL, M.D.
VICE PRESIDENT
THE NATIONAL COMMITTEE ON ALCOHOLISM

Condensed from an address given at the Annual Meeting of the National Committee on Alcoholism.

A TERRIBLY destructive process is at work in a man who may not even realize he is ill, or realizing the possibility, may be so on the defensive about it that he is unable to accept or even admit the reality of his alcoholism. In all probability he will attempt to hide his fright. He may be reckless with the truth in his endeavor to minimize the seriousness of historical and symptomatic factors.

Awaiting John's arrival at the doctor's office should be an atmosphere of calm preparedness to cope patiently, pleasantly but seriously, and above all honestly and objectively with whatever emotional or behavioral patterns unfold. Not just one life is at stake but that of John's wife and their children are singularly influenced. Colleagues and others less intimately involved may be none-the-less concerned. The stakes are high indeed. A mistake now may eventuate in untold complications in the lives of John and all those associated with him.

The earliest appointment possible was made for John lest his anxieties and mounting tensions precipitate an episode delaying treatment further and he is welcomed to the doctor's office just as any other patient. An office record is made quickly by the nurse whose studiously impersonal questions are asked quickly and privately out of hearing range of the other patients. John is not kept waiting but ushered as soon as possible to the doctor's private office where immediately a double examination is in progress, the doctor studying the

patient and vice versa. Not infrequently the vice versa is the more intense and poignant.

The doctor makes the usual inquiry regarding the reason for seeking medical help and learns from John that there is really no need for it and he apologizes for wasting the doctor's time. John's story reveals further that "the wife" has gone on an hysterical rampage which has upset the entire household and she has threatened dire consequences unless he sees the doctor. Actually, John feels perfectly well, not reporting at this point that it took "two or three" this morning to bolster his courage about seeing the doctor, and, of course, the latter does not reveal the mixture of bourbon and Sen-Sen which his nose knows, nor does the doctor at this point challenge the patient's veracity.

Physician And Friend

The most the doctor can do so soon is to be a good fellow and especially a good listener, inviting John to tell all, never "viewing with alarm" or reacting with "utter amazement." Great effort is being made to "identify" with John, to get him to like the doctor not only as a physician but as a friend, in a word: to establish good rapport. If the doctor is honest, sincere and really understands alcoholism as well as he does cancer or pneumonia, he will not have great difficulty with his alcoholic practice.

I. Q. Not Essential

Good intelligence is most helpful but it is not essential that the doctor's I. Q. be so high as his alcoholic patient's. A warm personal attitude or genuine fondness for troubled people coupled with wisdom born of sound experience is more valuable than academic brilliance.

The doctor makes as complete notations as possible in the record as John narrates the story of his developmental years. His school and college record, his military service experience, work record, his amours, marriage or marriages and troubles. Were the boys drinking alcohol and Coca-Cola when John was in school or had prohibition been repealed? Did John drink more or less than those others and were his reactions similar? Isn't it interesting how differently alcohol seems to affect people and how little it sometimes takes to "knock one off" as he grows older? Yes, it is a strange but pretty wonderful world after all!

Avoid Argument

The doctor may raise a quizzical eyebrow now and then but out and out argument must be avoided at all cost. It is clear to the doctor that John is a sick alcoholic and great care must be taken not to provide him a loophole through which he may escape and circumvent treatment. Consciously or unconsciously he has been searching for one and there is nothing he would like to tell his wife so much as "the doctor says a drink or two a day doesn't hurt anybody" or "Doc seems to think I had a bad hurt in my childhood and that if I see him for a little while he will resolve my neurosis and I can drink like anybody else."

The doctor agrees with John whenever possible but hues steadfastly to the theory that it is wise for everybody to have periodic medical examinations and to take stock from time to time not only of their physical well-being but of their emotional and even spiritual health. "It is later than you think," you know, and just how are you standing up against the vicissitudes of this crazy world in which we live?

Of course, the doctor agrees with John that women are strange biological creations and sometimes most difficult and intolerant. Certainly

John's wife was at fault to expect him to stop drinking as he promised if she would marry him. And of course she was careless not to teach the children greater respect for their father when they obviously avoided him after school on those occasions when John may have had "one or two too many."

At this point the doctor may test his status with the observation stated by Dr. Kanner of Johns Hopkins that children seem to learn by example rather than precept and sometimes feel rejected by a parent who over-indulges very often. No, this touches a sensitive area and cannot be pursued further but the medical history is sufficiently complete to move on to the physical and neurological examination which John welcomes because this cannot reflect on his character and it would be great anyway to be able to tell the doubting wife that "Doc couldn't find anything wrong with me."

When the physical examination is complete, blood and urine samples taken and John dressed and back with the doctor, who now carefully and seriously appraises the record, the time has come to quietly but confidently reveal his concern for John's health.

Physical Symptoms

The retinae are somewhat engorged, the optic nerve is blurred, the muscles of the tongue and lips are tremulous as are the hands and feet. John reports that he has always had a tremor of his hands and so this doesn't mean anything. The doctor agrees partially but comments on the interesting character of John's particular tremors and then too, the blood pressure is up somewhat, the pulse is very rapid and that tenderness in the liver region may be significant. In addition, the reflexes, particularly in the legs, are off a bit and the calf muscles are more tender to pressure than they should be.

Oh yes, John volunteers the "forgotten" information that his legs have been bothering him a little lately but a drink or two makes them feel better.

Here is an opening and of course the doctor can help the condition of John's legs and is eager to do so. But the doctor can now impress upon John that the medical problem is not so simple as a localized myositis or neuritis and further study in a hospital is the only sensible procedure. John rebels more or less at the prospect of hospitalization for manifest reasons of expense and lack of really crippling symptoms; the latent reason unexpressed is fear. John is brought around to see the wisdom of preventive medicine—an "ounce of prevention" you know, and after all there is a healthy form of selfishness.

Keys To Success

Office treatment might suffice in John's case because during recent years therapeutic aids have been greatly improved in the treatment of alcoholism but prompt action, thoroughness and follow-up are the keys to successful therapy. In the hospital however, John can devote his full time to learning to understand not only the medical nature of his illness but himself as a person. He is assured that he will be admitted to a good general hospital, received and treated like any other patient. While there, he may be encouraged to read constructive literature pertaining to his difficulty, meet and talk with others similarly afflicted, and benefit from the experiences of others who have recovered from both lesser and severer degrees of alcoholism.

Improved techniques of study and treatment now permit of considerable success with short hospitaliza-

tion periods. Much can be accomplished in a week or less. The cost is not great—often less than a case or two of good whiskey.

John finally yields, a room is secured and hospital admission effected promptly before John has time to call upon his countless intellectual resources whose facility to rationalize a change of heart are remarkable.

Of course, in return for his splendid cooperation, the doctor will see John's wife and "try to pound some sense into her head." Actually John's illness has affected the entire family adversely and an effort will be made to give her and the older children a more objective and less emotional conception of John's serious illness. Arrangements will be made to follow through because it is obvious to the doctor that John will need medical guidance for perhaps a year or so after his discharge from the hospital. Plans may be considered at the same time for enlisting whatever community aids are available and acceptable to John so that he may have the benefit of a multiphasic or "total push" approach to his problem, which experience teaches is preferable to any single medical or community discipline.

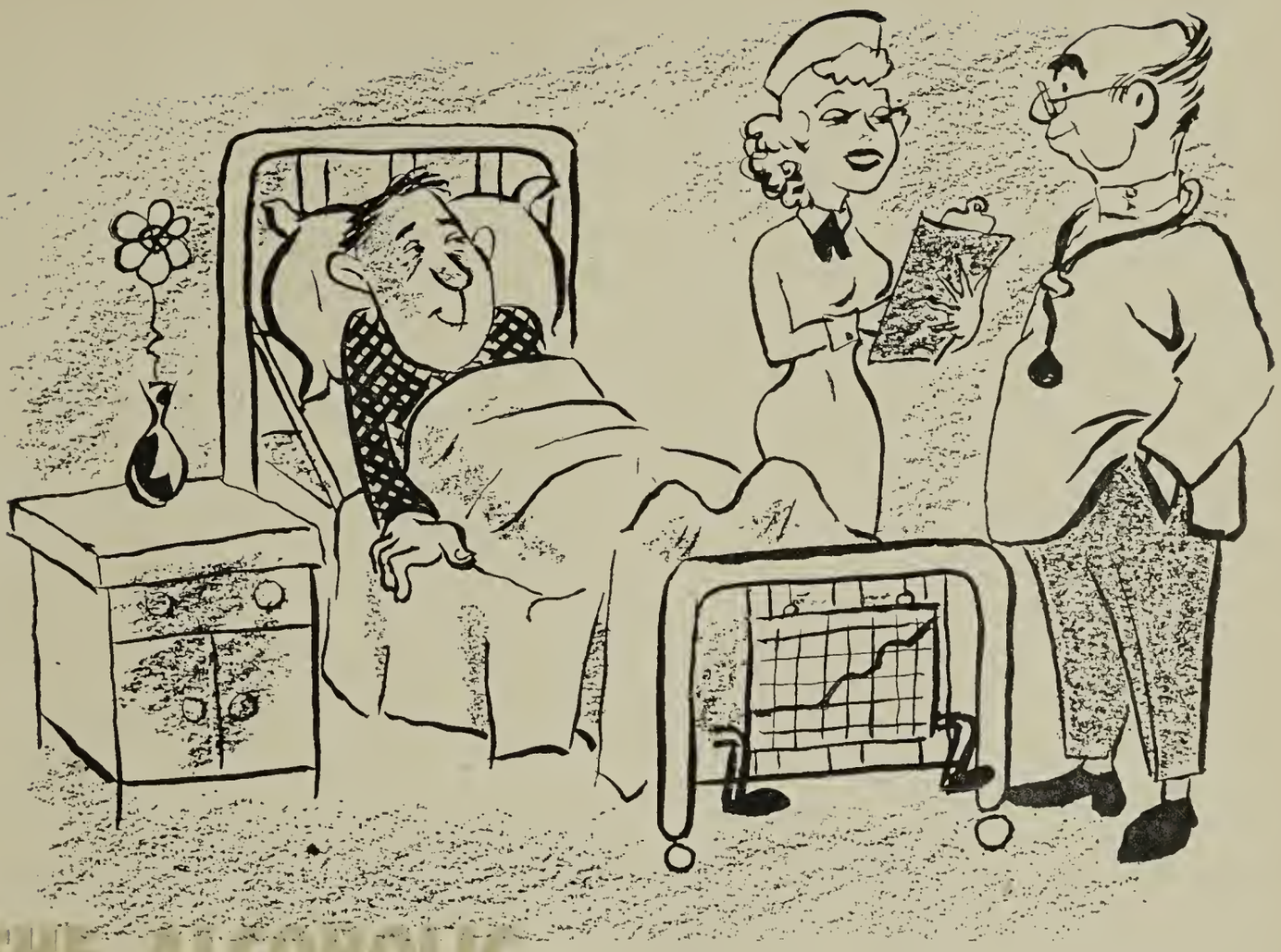
And so, John is off to the hospital and the doctor beckons wearily to the next patient with whom he can relax because this patient's trouble is only a brain tumor. He feels sick, eagerly seeks help, has no feeling of guilt or preconceived notions of diagnosis or treatment and breathes a sigh of relief when hospitalization is recommended and arranged. How easy this patient is for the doctor, but the prognosis is poor and the doctor saddened. John's illness is equally dangerous and ever so much more difficult to treat, but the doctor's satisfaction is great because the stage has been set not only for John's complete recovery but for the rehabilitation of his distraught family as well.

THE alcoholic is someone whose drinking causes a *continuing* problem in any department of his life. Since alcoholism is a progressive disease, the time inevitably comes when the urge to drink is completely *uncontrollable;* when the victim, once he begins to drink, stops only when he is too drunk to continue. His compulsion literally forces him to drink to drunkenness again and again, even when he is fully aware that he is damaging himself physically and mentally, destroying his family life, ruining his business, and finding no pleasure in his drinking.

—in *Three Approaches to One Goal*
Published by the National Committee on Alcoholism

EVEN if you sincerely desire to stop drinking, but attempt to do so without medical assistance, the chances are that you will be unable to continue to abstain. The underlying disorder that made you an alcoholic in the first place will probably drive you to drink again. In the common-sense re-education of the abnormal drinker, under psychiatric guidance, abstinence is a big step forward. But it is only the first step of a reorganization of yourself that will be the most important thing in your life.

—Robert V. Seliger, M.D., in *Alcoholics Are Sick People*



THE ALCOHOLIC IN THE HOSPITAL

BY ROBERT H. LOWE, M.D.

FORMER ADMINISTRATOR
ROCHESTER GENERAL HOSPITAL
ROCHESTER, NEW YORK

The sick alcoholic needs and deserves hospital facilities.

WHEN John came to us for admission he did not realize how markedly changed is the manner of his reception from what it would have been three to four years ago.

Formerly, if he had requested admission with the frank diagnosis of 'Alcoholism' I am sorry to say that in all probability he, or his attending physician, would have been told very frankly and brusquely, "Sorry, we have no beds."

Consequently, physicians trying to help their patients were 'sneaking' those patients in with false diagnoses. The admitting clerks recognized what was being attempted and were often down-right discourteous.

A change in this attitude was not accomplished merely by an order from the front office. Instead, a concentrated effort was made to persuade hospital personnel to interpret with a broad understanding the five major functions of a non-specialty hospital:

Condensed from an address given at the Annual Meeting of the National Committee on Alcoholism, March, 1954.

1. Care of the sick and injured.
2. Service to the community.
3. Education of personnel.
4. Public health prevention of disease and promotion of health.
5. Advancement of research.

This interpretation was not easy to secure and we are certain now that if we had waited to try the suit on without any fittings we would not be wearing the suit today.

As we have reviewed the development of the program we found that the following major hurdles had to be cleared:

1. Attitudes of personnel, including those of the emergency and admitting departments, the house staff, the nurses and the graduate staff.
2. Hospital procedures and safeguards.
3. Nursing care.
4. Why a general hospital rather than a nursing home or a sanitarium?
5. The role of psychiatrist and medical social workers.

Hitherto, when a patient carrying an aromatic odor had been brought into the emergency department or the admission of a suspect had been requested, the Iron Curtain rolled down, a police car was called, and the patient was whisked to the alcoholic ward of the city or state hospital.

The attitude of the emergency department supervisor and the admitting clerk had to be changed. I must admit that several very certain decisions from the front office were necessary. These decisions coupled with careful explanations were accepted and soon everyone was playing ball.

Next came the orientation of nursing service personnel. Side-boards, restraints, strong rooms, verbal abuse, all made the chores of the nursing personnel apparently greater. Again, indoctrination of nursing personnel, through the nursing office, that these patients are SICK but that they require no more nursing attention than does the patient in diabetic coma, with acute cardiac collapse, or a fractured hip; believe it or not, this task was amazingly easy. One thing that made it easy was the amazement and gratitude expressed by the alcoholics to the nursing personnel at their being treated as sick people.

Probably our hardest job was with the house staff, (interns and residents). Why should they spend a great deal of time examining and attempting to elicit information from this reticent patient who did not know enough "to take care of himself." This part of the program requires annual review, because our house staff changes every year. Fortunately, the permanent personnel and the hold-over residents help materially. Also of great help is that this *disease* is now being treated scientifically and not just as a "cure."

Attitudes

Last, but not least, was the attitude of the practicing medical staff. With the shortage of beds as acute as it has been with us for the past several years, it was hard for a staff member to understand why his patient with a "coronary" couldn't be given a bed when several hospital beds were occupied by "drunks sleeping it off." The work of the Rochester Committee for Education on Alcoholism and interested physicians has permeated the entire community and by osmosis the staff has become educated.

The Iron Curtain has been furled for good.

There have been no marked deviations from standard procedures. Patients of this type are admitted as are any other patients. We do not believe in segregating them, and they are admitted wherever there is a bed available. The unsolicited expressions of amazement and gratitude from these patients, that they have not

been treated as pariahs, has convinced us that the policy of segregation is not good.

Restraints are used initially if indicated; strong rooms, never. As for barred windows, we have none.

In this day of nursing shortages the hospital administrator cannot help but ask what additional load this is going to place on his nurses.

There is the troublesome first stage sometimes, when the patient is admitted. Yet again we emphasize that these patients need no more attention then do other acutely ill patients. Usually the first 24 hours is all the acute phase lasts and then the patient is out of bed and, in order to pass his time away, is helping nursing personnel care for other patients.

The average length of hospitalization is five days.

After this description of how simple the hospital and nursing care are, one may rightly ask why should these patients be hospitalized? Why not put them in a nursing home?

Examination has revealed that these patients may be far off balance physically. Accordingly, most of the following tests and examinations are performed on all patients: glucose tolerance; liver function; adrenalin-eosinophile; ACTH-eosinophile level; radioactive iodine-BMR; EKG and EEG.

Virtually all of these tests are performed to discover if there is an imbalance in the functioning of the endocrine glands. Investigation has revealed that an imbalance in the functioning of these endocrine glands may be the cause of misdirected energy which, if corrected, leads to recovery. What other disease is being treated more scientifically or needs the facilities of a hospital more? Where else, than in a hospital, can these examinations be performed?

Perchance this is being unfair to psychiatrists and medical social workers, but experience has shown that in the initial phase this type of patient does not accept this type of counseling unless it is very adroitly handled. They believe they are sick, not "queer." Many, many times, however, there is a very definite need for such consultations after the acute phase has passed and the attending physician should be alert and secure such assistance.

Community Responsibility

It is particularly significant to us that the community has recognized its responsibility in meeting the challenge of recognizing and treating alcoholism as a disease, curing and returning the sick person to work. Many Blue Cross Plans today underwrite five days of hospital expenses in any one year for this type of treatment.

Now I should like to revert to attitudes—this time not those of hospital personnel, but those of the patients and Alcoholics Anonymous.

In 1949 a clinic was started in Rochester in a building disassociated from any hospital. Its case load grew tremendously. The out-patient clinic facilities of a hospital were offered the following year. A cross sampling of physicians and members of AA working in the clinic as well as patients attending the clinic disclosed a still present fear of a hospital in connection with treatment on an ambulatory basis.

Today this "fear" has been erased and approximately one year ago the originally offered out-patient clinic facilities were accepted and the clinic for alcoholism meets one full day a week.

The community supports the hospital. In return the hospital must support the community, and it can do so without any revolutionary changes in manner of operation.

THE ALCOHOLIC IN THE CLINIC

BY DAVID G. MYERSON, M.D.
CLINICAL DIRECTOR
NEW HAMPSHIRE COMMISSION ON ALCOHOLISM

A psychiatrist describes his approach to the alcoholic patient.

MY responsibility is to discuss with you what I, as the psychiatrist of the New Hampshire Division on Alcoholism, try to do with the alcoholic patient after he has sobered up and recovered from the unpleasant after-effects of his long drinking spell. I think it is well known that our treatment begins at the moment we meet the patient and may last many, many months, long after his discharge from the hospital. Essentially then, my treatment is on an out-patient basis. We may see each other once or twice a week, if practical, and the interview may last half an hour to an hour.

What is the purpose of this time consuming procedure? Generally, I would say that I try to help the patient change his mode of adjustment from one of more or less complete reliance upon alcohol to self-reliance; from complete evasion of life with all its problems to facing it; from an extraordinarily destructive self-gratification to higher and more mature gratification. In short, I try to help the alcoholic patient help himself in as many life situations as possible; to face his problems even if he cannot solve them, rather than to blind himself through the abnormal use of alcohol.

In order to avoid a too generalized discussion, I prefer to limit myself to

Condensed from an address given at the Annual Meeting of the National Committee on Alcoholism, March, 1954.

two extremely important problems of treatment. First, what is the motivation that faces the patient so that he presents himself for help? Second, what present and pressing emotions face the patient if and when he is able to renounce alcohol?

In regard to motivation, careful evaluation of this is of basic importance, not only in planning treatment but in predicting the outcome. We must keep in mind always that words do not really matter. We have all met and have been disappointed by the man who promises that he will never drink again, that he will do anything we say, and who never shows up for his second appointment. And, conversely, we know the man who is forced in by the courts, who expresses his defiance openly and vociferously, but who, if handled with tact and patience, is desperate for help.

Life History Helpful

So we do not judge a man from what he says, but from a careful history and evaluation of the patient's life. What has been going on in this person's life? And the answer to this question may take time, considerable time, before it is revealed. We may discover that the man's wife has threatened separation and he comes for help to get her back, or his boss has threatened: "Get help or else." Or a man may see himself as disgusting, dirty and sick, facing loss of love from all those around him, facing the catastrophe of being alone, completely alone.

Thus for the successful renunciation of alcohol there must be powerful motivating forces. To succeed, a revolution in the man's life has to take place. For the alcoholic, alcohol, with its unique physiologic effects and pleasure, is his world, and all values, usually held dear, are secondary. To renounce this world of strange pleasure, or really a kind of numbness, something drastic must happen either to the outer or inner existence of the patient. Thus, the patient must face an "either—or" prospect. Either he continues to drink and faces a life of loneliness, a loss of all his values, a loss of protection, sickness, and perhaps death—or he gives up drinking, painful as this sacrifice is.

From our point of view, we may ask, (1) What forces the man to seek help? (2) Is it an inner revulsion with real fear of his present mode of life? (3) Or is he being forced by the outside, e.g., the law or his wife, to seek this help? I think it is obvious that motivating forces from within, such as fear and disgust, are bound to get stronger and more effective, no matter what the treatment, than motivation from without. We know, as a rule, how poorly we do with the patient who is dragged in by his wife "to get him straightened out." Even so, one of our basic questions is this: Is there any way we can change a poorly or weakly motivated person and help him toward more adequate motivational forces? This presents a difficult problem and one which, I fear, cannot be answered in any schematic way.

No Handouts

If the patient renounces alcohol, more often than not, we are faced with economic and social problems, which I do not wish to discuss in any detail—not that they are unimportant, but they are in the province of the social worker. A word of caution about this, however, which we tend to employ in the New Hampshire Clinic—namely, we avoid at all costs handouts or doing the work for the patient. For example, if he has lost his job, we do not get him one, but rather tell him what community resources he himself can seek to ob-

tain reemployment. But what I, as a psychiatrist, am concerned with are the emotional problems which the patient has to face without alcohol. Now I meet many situations, so that it is hard to generalize or summarize.

I can say this, however: I prefer to approach the problems that lie on the surface, so to speak, those which seem to be salient. I have learned from experience not to go deeply into the personality make-up. As a rule, I consider it unwise and impractical to penetrate into the past and unconscious and to make interpretations to the patient based on these observations. For example, I set my goal to help a marital situation, or difficulty in adjusting to people, or a problem of inferiority.

Rather than go on in a general way, let me continue with our patient John who has now sobered up and is willing to talk to the psychiatrist. Supposing he says, "I'm all through . . . I'm all through . . . I'll never drink again . . . I can take it or leave it. It doesn't mean anything to me. Really now, it's no problem at all." We listen patiently—with eyebrows secretly raised, because what he is saying is, "Leave me alone . . . I can drink if I want to . . . I don't *have* to give it up because you or anybody else says so."

Motivation

We know we cannot evaluate him, because his guard is up, and if there is really desire for help, it can be ruined by premature pushing. So we ask him to go ahead and describe how he got to us. Then he begins a long story of his difficulty with his wife, how she finally told him to leave, how he violently protested, and finally, as a compromise, he came to the hospital. The picture in his case becomes clearer. His motivation is to get her back. He is going to show her, us too, and play on her guilt feelings by crying, "I suffer so much for you. I even talk to the wretched psychiatrist—so you *have* to take me back."

We know that sobriety will be temporary, perhaps until the crisis is over and his wife takes him back. We may or may not talk it over with the wife.

And then, one day, let us say, after another binge, he is really threatened: Not only his wife is horrified at his rage during this drinking spell, but the patient, too, is frightened. His oldest boy tells him he hates him. His boss finds out and puts him on probation. And the police visit him and tell him his other son, the apple of his eye at one time, is on his way to becoming a juvenile delinquent.

Here you have the catastrophe which faces this patient. Either he faces it and struggles through the pain of reconstruction, or else he runs away into the Never-Never Land of the Skid Row community.

Admitting The Problem

But he comes back, and our noncritical and accepting attitude of the past pays off. He knows where he can get help and he comes to us—frightened, confused and desperate. He describes himself differently now: Drinking is *such* a problem. He has to drink, he feels, because he cannot control himself any other way. His wife and even his children get him so mad that it seems the only way out. He feels he has to drink to extinction, lest he run amuck and destroy these people around him. He thought it was better to drink in the barroom, where, even if he did lose his temper, he felt it was relatively safe. But this time he realized the drinking made him more violent. He wanted to know if he were going crazy and should be put away in the "violent ward."

What a life! He has to drink to control himself, and the more he

drinks, the angrier his family gets; the angrier he gets, the more he has to drink. And finally, he reaches the maddening vicious circle of the more he drinks, the less control he has, unless he drinks himself into a real stupor or ends up incarcerated in a hospital with the D. T.'s or some such horrible experience. It seems to him that the whole world hates him, and he cannot trust anybody,—essentially because he cannot trust himself.

Motivation Changes

The motivation has changed, of course. He is frightened this time of himself. It is not that he doesn't want to drink but that he doesn't *dare* to drink. And so finally, he maintains sobriety. But he is not at ease. There is no "peace of mind." Not yet, for he still has the problem with his wife. This is rather obviously the most important problem that faces the man and the woman, now that he has advanced this far. We can now proceed with the situation in the same vein as before. The man can trust me, to a certain extent anyway. He can talk about the marriage to a non-critical, non-moralizing and non-judging person. It's a kind of "Let's see what it's all about. Let's see what we can do about it if we try to face it."

Dependency Needs

Gradually, over a period of time and observation, another vicious circle becomes evident. The patient may be the type of individual who has strong dependency needs which become fixed on his wife. This may reveal itself in any number of ways: He may give her his money and have her pay the bills. He may want her to make decisions about work. Indeed, any decision that comes up in life, be it work, play, children, sex, or what you will, he yearns for her approval and judgment. Yet, at the same time, he hates himself for this dependency, which hatred he projects on to her, his wife. He blames her for weakening him. He also builds up hatred toward his children, because they, in a sense, are his rivals for the mother.

We are not particularly concerned from the point of view of treatment how this developed. Clues to his behavior may be ascertained in his previous relationship to his mother, but it is not always necessary to have the patient see it clearly. I am usually content if the patient sees the relationship clearly with his wife and can be taught and encouraged to try to master his own dependency needs, which to a certain extent can be done.

Wife Needs Help

As so often happens, we may find that the wife herself needs help, not that she is at fault. After all, years of abuse, disappointment and tension destroy love and create hostility, no matter how masochistic she is. Almost always, hostility on her part is present, often quite subtly expressed and sometimes dangerously provoking. She may spend money recklessly or nag, or expose herself as the long-suffering one in order to get her revenge. If she can be helped to give this up, a great deal of progress can be made. It is difficult to help, because we say the wife may feel that we are blaming her, and, no matter what we say, this feeling is present.

To approach this problem of his dependency on her and her role in this problem may be impossible except after a great deal of time. It may be that she has a need for a weak, dependent man and finds it difficult to tolerate any strength in her man. This is such a touchy problem with the woman that I am content to teach her that his dependency is a problem and she must, in a sense, allow

him to grow up.

And so it goes! A great deal of work! Patience and acceptance and tolerance and understanding. We judge only from motivation—not a critical judgment but from the point of view as to how much we can expect to help. When the motivation is weak and the guard is up, we do not delve into emotional problems. We wait a long time; it may never come about. Yet I think we have all learned from experience that even the most resistant patient, the most poorly motivated may change, given time.

It is my complete belief that, with such a complicated problem as alcoholism, no one approach is enough. We have the clergy, the sociologist and social worker, the physician, the neurologist and the psychiatrist. Each by himself is ineffective, but together in a team, a great deal can be accomplished. But the patient needs more than what the professional worker can offer. He needs to belong to a group, the members of which have similar problems, where he can be accepted, where he can be reminded daily of his struggle, for it is a daily struggle. I refer, of course, to the unique organization of Alcoholics Anonymous, whose work has become nationally recognized in the total treatment of the alcoholic.

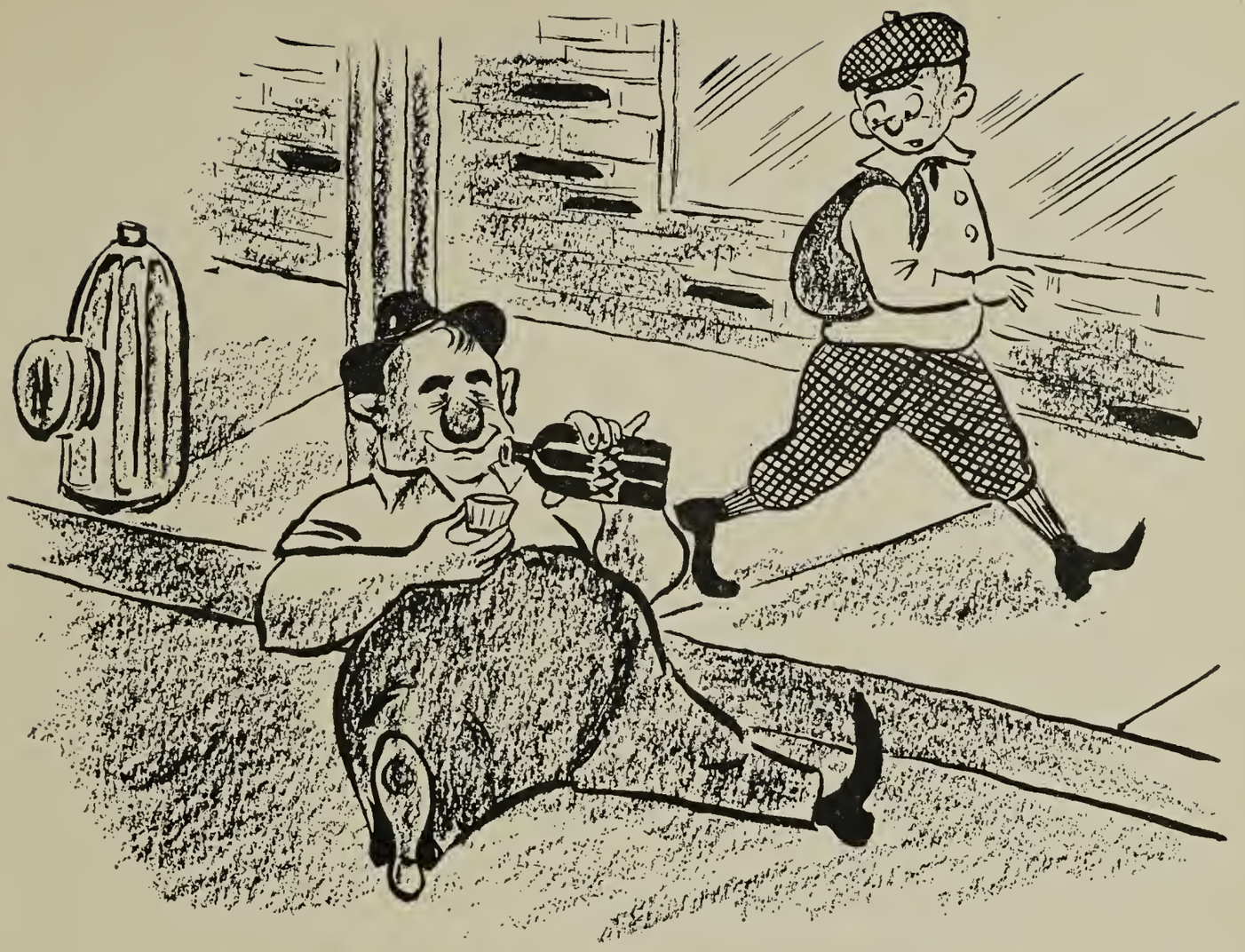
In conclusion, let me state that the psychotherapeutic method we have utilized with alcoholic patients in our clinic seems justified and points the way to a worthwhile approach to the whole problem of alcoholism.

NEW PUBLICATIONS

FREE FOR THE ASKING

NCARP TREATMENT CENTER BROCHURE through word descriptions and photographs, explains what the patient can expect during his 28-day stay at the NCARP Treatment Center—including treatment methods, recreation, diet, entrance requirements, rules and regulations, and daily schedule. This publication should be of interest to prospective patients, and to ministers, social workers, physicians, nurses, and others who come into contact with problem drinkers who need help.

THE NEW CORNERSTONE a basic manual on alcohol and alcoholism, is now available. Written in straightforward, simple language, this comprehensive booklet should prove helpful to both the layman and the professional worker who wishes to gain a better understanding of the background and development of alcohol problems. Some of the chapter titles include: Social Drinking and Alcoholism, Facts About Alcohol, Alcohol and the Human Body, Why People Drink, How to Help an Alcoholic, and Treatment for Alcoholism.



I AM AN ALCOHOLIC

ANONYMOUS

Condensed from an address given at the Annual Meeting of the National Committee on Alcoholism, March, 1954.

I AM John Doe, let me call myself, and the simple fact is that I am an alcoholic, not an alleged alcoholic. I can express only my own opinion, and I might add that everything I say is based on hindsight, for I had no idea what the devil was wrong while I was qualifying as a practicing alcoholic. I had some ideas, it is true, and most of them concluded with the idea that the world was very much out of joint, that I was born to be misunderstood except by a few very intelligent bartenders and a couple of women (not my wife). Later I harbored the illusion which I have since learned is very common amongst the brethren — that I was nuts.

At any rate, I secretly knew that I was a special phenomenon, and I think I rather liked that self-imposed distinction, because if everything else failed, as it was inevitably doing, I was at least a howling success as a freak. I had always wanted to do something different.

I have been made aware through experience as an alcoholic Munchausen that one of the troubles of my hindsight is that I tend to embroider the simple home-spun with almost

unbelievably fanciful designs. You probably have noticed that tendency in some others of us and you are therefore forewarned. However, there are compelling reasons for telling the truth here, as nearly as I can —one of them being that it's easier to remember.

Perhaps if my story has any value at all, it's the story of an ordinary man who became an ordinary drunk through diligent, ordinary application.

Early History

I was born into and grew up in a loving family, a middle-class family in which there was no drinking at all, in a small city where drinking was actually the exception and where the drunkard was a horrible example of mental, moral and sometimes physical weakness—or where wealth, sometimes family trouble, or pain, excused excesses. I had a drinking uncle, by the way. I loved my whole family, but I think I secretly loved him best of all.

I think I had a fairly normal childhood, along with solid church training and a full high school education that led me to college.

I arrived at college with a painful case of shyness and a very thin skin. And I discovered that alcohol helped to dull the pain of shyness, and I believe I turned at that moment from other solutions, that is, from developing other solutions, and relied on bootleg when the pain came. Liquor and college, of course, did not mix, and I was permitted to resign from the University by request.

For years thereafter I carried a resentment against what I chose to call "intellectualism" which might mean anybody who belongs to the Book-of-the-Month Club. But really, down deep, I did begin to harbor some doubts about myself. I began to seek my fortune in the world of prohibition, and I continued to use alcohol straight from the bathtub. I took the blackout in stride; everybody was having them. I took some mighty florid behavior for granted, too, because everybody was doing it. That is, I thought they were. It didn't seem grim at all, at that time, that hectic life I was going through.

Somewhere along there I managed to drift into the trade which has been my work ever since, off and on. And in this trade, which is journalism, I found new drinking companions and it was a comfort to believe that I was only following the custom of the ancient craft when I drank to oblivion and when I later took the morning drinks along-side the boys as an unashamed part of hard living.

I began to go on the wagon, though, because my body folded up occasionally and I had to show myself that I could take it or leave it alone. In a prolonged period of firm resolution and good behavior, when I was giving a good imitation of a normal, well-adjusted human being (I was a pretty good actor in those days), I got married. I was extremely lucky. My wife was innocent of any attitudes toward alcohol, and neither she nor I could have foreseen the hard times to come.

The Genie In The Bottle

Over the years, as we had our children, and as I tried to get ahead, my genie in the bottle lived with us, and he grew bigger and more important as time went on. I began to make sweeping decisions to lay off the stuff completely and often did, for brief eternities. These decisions were particularly heartfelt after bouts with real trouble which I will not go into. During this time I was introduced to that dream-world of barbiturates and was honored by a visit of the cops to my house on the occasion of my decision during a black-out to do

violence to the whole family.

After each incident I, of course, was off the stuff. I was drinking too much, that's all there was to it; of course I know all about this alcoholism business. I had thought real alcoholism was when you went to the Bowery to finish off your drinking. I often recommended Alcoholics Anonymous to my drunken friends and several took my advice and switched to coffee, and are very happy men today. Of course *they* were drunks. *I* just drank too much, and I was the guy who could control it— that is, next time. It was a next time, of course, that never came.

A half a dozen years ago I asked my doctor to hospitalize me: I was suddenly faced with a new job which would have meant a new career (I needed one badly at the time) and my doctor hemmed and hawed. He said, "Well, I'll be glad to do so, but you'll have to learn the symptoms of a disease."

I said, "All right, what is it?"

"Diverticulosis."

Changing The Pattern

Well, he told me what they were and it was easy, with my highly developed rationale, to not only learn the symptoms of diverticulosis, but to have it forthwith. And therefore drinking was not my problem.

Well, I got the job and I stopped drinking for six months. But this is a familiar story again. I followed a careful regimen of controlled drinking. I was on beer. Beer doesn't hurt anybody. Wine doesn't hurt anybody. Well, you know the answer. In six months after that first drink (of course this timing doesn't mean anything, but sometime after that first drink) I was drinking the clock around, and once again it was a nightmare.

I found I couldn't stop. At first my biggest problem was trying to re-

member where I had hidden that bottle the night before. Next, was trying to placate my wife once again. I had no trouble keeping away from my children when I was drunk because they kept away from me.

I didn't want to see my friends, and I'm sure they didn't want to see me unless they were drinking, too. And so on, ad nauseam.

Awareness Of Problem

Then it got to be too much for my boss and he fired me. This was the third time and, in the small world that I thought I lived in, that was out. I was sure that I was washed up. But that gave me only momentary concern as long as I could drink, and of course I got to hate the days and wished for the nights. Then I got to hate the nights and wished for the dawn and the bottle. Money was running out. That didn't concern me. Love was running out, or I thought so. That didn't concern me. And I was running out.

It's no wonder that suicide occurred to my over-dramatic mind but the courage to commit it was lacking. Somewhere in the back of this sodden head of mine was the notion that I must stop somehow but by that time I had developed a fear of stopping—of losing my last comfort.

Family Attitude Changes

I was getting to the end of a dead-end street, and then one day for some reason or other I noticed something different around the house—a difference in the atmosphere. How I was able to detect it, I don't know. My wife had changed. She didn't seem to be weepy; she no longer stabbed me with the blind anger of her frustration, and out of the corner of my eye I caught the kids giving me the once-over look. In short, I began to feel a rather impersonal clinical atmosphere developing. Something seemed to say, "Go right ahead and drink. We're waiting."

I was completely baffled. I've often imagined since that a bull in a bullring must feel something like this when he finds nothing but the cloth of the cape mocking his horns when he makes the charge. Well, of course I got drunker; I tried to paw the earth too. And when I aroused there was still the air of ministration, a clinical air with something of a faintness of hope in it. I don't know how to describe it, but that's the nearest I can come.

The Information Center

I didn't realize at the time that something else had stepped into the shambles of our lives and even then was beginning to bring some show of order to it. That's hindsight, of course, I remind you, because my wife had in desperation followed up a lead she had read in a magazine and she'd called the nearest Information Center and she had begun her education. She'd also brought some literature home as I learned by finding Marty Mann's PRIMER and which I promptly threw across the room.

I was no alcoholic bum and this was not for me, but I don't know, something stuck. And I don't know why I went with my wife, but it wasn't many days before I tottered into the Information Center at her side, determined to see what this was all about and maybe do a story about it. Good idea.

Well, the man there didn't seem a bit surprised to see me. He had that sort of clinical air too, that "kindly" business. But he also had warmth as he shook my hand and said, "Now you get over to see the doctor, and come back after you've seen him. I want to talk to you."

I thought okay, I'll never see *him* again, but in half an hour we were

over at Dr. J's. Things happened fast. I wanted to go home first; there was a bottle there and I wanted a drink. But he said, "Well, it's now twelve o'clock. There's a bed for you at the hospital at one." Oh my gracious, I can't get ready to go to the hospital at one. I've got to go in and see about a job and so on. I could have made up a darn good one for him if he'd given me time but he didn't give me time. So I was in the hospital at one o'clock and in bed at 1:05.

Clinical Treatment

I resented being kept off my feet, but somehow I couldn't get them planted. I did manage to get a couple of drinks down and nobody seemed to care whether I did or not, so I had them anyway and they didn't do me any good. My wife left and I was left to the really superior clinical atmosphere.

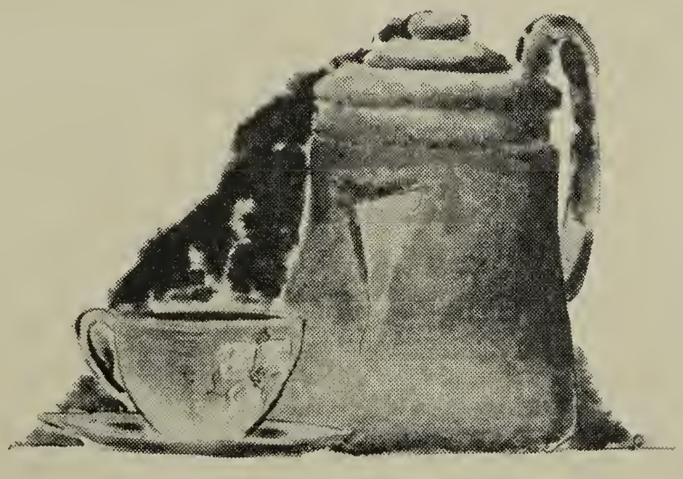
I emerged five days later steady and completely lifeless. I felt like a vacuum going somewhere to do nothing. I walked and I talked and I lived like an automaton.

I talked with the counsellor at the Information Center, my doctor, and the psychiatrist, and they led me gently to the information that I was not a special case by any manner of means, that there were probably four million others like me, that I suffered from a recognized disease and if I wanted to recover, I mustn't drink. That I must take up some sort of a hobby. That I must curb my impatience during my convalescence and that might take some time. And that I must try to build new thoughts up, and that I must watch my euphoria. And I must remember, when I began to feel better, that I was simply approaching the level of normalcy and not becoming a superman. And, above all, that I must listen just for a little while with my own ears to what other people have to say. Yes, the first job is to convalesce, because my first job was to get over this thing. Later, maybe, you talk about other jobs and mainly one to make money, but right now let's get over this thing.

Well, I accepted this because all the fight was out of me. I can't say that I had much hope at this time, *but all of them did.* So it was okay, do what the man said, what else *can* you do?

Two months later my life was beginning to warm within me but something was lacking. I was still friendless and alone, I thought. I was still in professional hands, competent professional hands that I respected by this time. But I wanted something else.

My advisers were happy to hear



about this. They agreed. They said, "That's fine. It's good for you."

My clinician suggested that he knew a group of people like myself who were doing just what I was trying to do, and they were doing it together. So he wrote a telephone number on a piece of paper and said, "Call him up." He said the man was a member of Alcoholics Anonymous.

Right away the resentment flared—automatic. I was doing all right. Why expose myself to a bunch of people who were going to—well, I don't know what they were going to do. Especially in my own community where I was so well known. But in a day or two, I'd had a chance to review a few pieces of reading matter which said that AA was the one big supportive therapy for people like me, and I was reminded I mustn't forget this—that AA's got up in the middle of the night and went out to bars to help others. That appealed to me dramatically. I thought I could join this great crusade. So I said to my wife, "My dear, AA needs me." And I called the number.

First A.A. Meeting

The man wasn't very impressed about my offer of services. He said, "Well, come along." Well, that night I went to my local group anyway.

Like so many other people, I don't remember what happened that night, what was said. I know what happened to me. I was flooded with a feeling, a feeling that I have never been able to describe. Nobody seemed surprised there either. The butcher, the baker, the lawyer, the doctor, the business men in town, men and women, all there—a cross section of the life of our community. They didn't look like drunks to me. And their happiness and collective serenity filled my empty heart.

That was my stepping stone. And in AA I found in practice all the theories that I heard in the doctor's office, in the clinic and in the Information Center. There I was enabled with AA's help to practice these things and more that only experience can give you.

I was told, when I first went into AA, that I must surrender my whole self. My life had been unmanageable, surely. It wasn't hard, as the days went by, to understand that my alcoholism was the root of my lifetime of troubles . . . leading to my own particular, peculiar personal disaster. The picture began to make some kind of sense.

They told me to take a daily inventory, and I did. I found that it made a pattern. I found that I was powerless over alcohol.

Surrender Not Easy

Surrender was not easy. My guides suggested that since sobriety was the basis on which I must found my new life that was my first job—just as the doctors told me. (First things first, in other words). I must not expect that new life nor any of its benefits at once, but eventually some sort of reward would come. (Easy does it). That I must turn my life over to a Will greater than mine; I couldn't do it alone. At least no one else had gotten away with doing it alone, and certainly I hadn't.

Understanding Friends

"*Thy* will be done" was very hard to do, and is a daily task. Now, those things have eased somewhat—under the gentle guidance of this collective love and this collective experience. I had others to share my troubles with, my hidden desires, my flaring compulsions, my temper tantrums. The smallest detail was gravely discussed. Nothing was too small to talk about. The clinic and the professional stepping stones were behind me and remembered, but here

was the personal 24-hour plan for my continued sobriety, if I wanted to use it.

Yes, the rewards came, and ones I didn't expect. The love of my family burst on me like a summer storm. My children glowed in the promise of a new father. My wife and I knew each other and loved each other as we never did before. My friends seemed to breathe a sigh of relief, and I certainly did, when I met them. The past, AA said, I could no nothing about. The future was in hands more capable than my own. The present was my package to wrap neatly against time.

New Meaning To Life

When the surrender did finally come, I don't know. At what hour, I don't know. But I learned a new relationship with some of the mysteries of life, the things that had been mysterious to me before, and a new meaning to life's manifestations.

"Ah," but AA said, "That's euphoria; that's the honeymoon." But it was a slow dawning of splendor. And, thanks to my guides, I think I was ready for it.

Today, life falls more neatly into everyday rhythms. The job is never done, I'm sure of that. And I have a little formula (We all have our formulas, I suppose.) My little formula is that every day I have to remind myself that I am an alcoholic. I do this much the same as my friend across the street reminds himself that he is a diabetic and therefore must take his insulin, if he is to live and enjoy life. So, I'm an alcoholic, and, far from being a morbid thought now, it is a joyful one. It puts me into joyful company with my friends in AA, and also with the normal world.

Religion Helps

And church again now has come to have some meaning in my life. I can understand the words, and, without getting too complicated about it, I think I can say this: that AA has taught me of the reality of faith. So that now, even though I struggle to have faith itself, at least it has taught me *to have faith in faith.*

I don't know how far I've come, I can't measure it. But I would like to tell you of one affirmation which is of great satisfaction to me. I have a daughter named Susan. Every summer she goes to the Adirondacks with an outing club, and it was a summer not so far back that she came home and was enthusiastically telling her mother about the good time she had had; as she always does, and in the end she said, "But you know, the best part of my trip this year was that I really *wanted* to come home."

ON a hot summer day, a cowboy riding along a dusty street stopped at a small town saloon and tied his horse to the railing. Entering the saloon, he walked up to the bar and ordered a large pail of beer. Carrying the beer outside, he placed it where the horse could reach it. The horse drank the beer and when the cowbody brought the bucket back to the bar, the bartender said, "I like people who are kind to horses. Let me buy you a drink." "No, thank you," said the cowboy, "I'm driving."

THE N. C. A. R. P.-
A PROGRESS REPORT

Much has been accomplished in the five years that the State Program has existed, but the fight has just begun.

IT has been almost five years since the State Legislature passed the Act establishing the N. C. Alcoholic Rehabilitation Program. During this relatively short period of time, notable strides have been made toward lifting the haze of misconception which has long obstructed effective help for citizens suffering from the illness of alcoholism.

Not many years ago, the alcoholic was society's outcast. He was looked down upon, if he was noticed at all, by those who proclaimed him a weak-willed bum lacking in self-respect. He was thrown into jail, he was preached to, committed to mental hospitals, destined for damnation, berated, or ignored. And very few could understand why, after society had given him the "works," his alcoholism for the most part remained uncontrolled. This situation was just as true in North Carolina as it was anywhere else.

Almost the only constructive action being taken in North Carolina to *help* the alcoholic prior to 1949 was through the fellowship of Alcoholics Anonymous, just then beginning to catch on and grow.

Misconceptions held for a long time become increasingly hard to eradicate. But during the '40's, science was advancing a new set of concepts as a result of clinical experience and research. Basic to scientific findings was the conviction that the alcoholic is a *sick* person. Further, that he can be helped to recovery with the proper professional assistance. Behavioral scientists, after careful study, even concluded that the tragic illness could be prevented in future citizens by

providing children with wholesome emotional environments in homes and schools.

Though the majority of our citizens were not yet ready to accept all of these new ideas, North Carolina was fortunate in having leaders who saw the plight of our alcoholic population and set about to control this public health problem, using the new knowledge as a foundation. North Carolina was among the first of the forty-eight states to take constructive action.

The Alcoholic Rehabilitation Act of 1949, sponsored in the Legislature by Representatives Umstead, Blue, and Kilpatrick, clearly recognized the tremendous scope of the problems of alcoholism. In essence, it proposed attacking the problem on several fronts. First, it recognized the necessity of providing treatment facilities for rehabilitation of alcoholics and problem drinkers. Second, it provided for education activities aimed at informing the public of the facts about the nature and development of the illness. And equally important, it granted authority to carry on "mental health activities" leading to the ultimate prevention of the illness.

Funds in the amount of $300,000 were appropriated to the State Hospitals Board of Control to implement the Act. The Hospitals Board appointed a full-time Executive Director, and the new Program was launched. It has since been recognized as one of the model Programs on Alcoholism in the nation.

Treatment Center Opens

Arrangements were made for the establishment of the N. C. Alcoholic Rehabilitation Center at Butner, N. C., and the first white male patients were accepted on September 1, 1950. More recently, facilities for females have been added. The Treatment Center embodied a unique concept, based on the best scientific opinion available; namely, that alcoholism is a personality illness. Treatment was aimed toward re-integration and readjustment of the alcoholic's whole personality. Psychotherapy in the form of group discussions led by clinical personnel was established as the backbone of the 28-day treatment. Group therapy was reinforced with a program of educational films, individual consultations with the doctors, recreation, rest, proper diet, and prescribed medications.

Treatment Limitations

Treatment at the Center was to serve as the *foundation* of continuing sobriety. It could not be expected to iron out in only 28 days all the personality difficulties which the alcoholic had developed during the long course of his illness. Working arrangements were made with already existing Mental Hygiene Clinics over the State to provide out-patient treatment services for alcoholics (and their families when deemed necessary). Patients were informed of this service and urged to follow their treatment at the Center with visits to the Clinic nearest their homes. To promote good liaison between these out-patient clinics, the Treatment Center, and the ARP offices, a Psychiatric Social Work Consultant has recently been added to the administrative staff.

Education And Information

Treatment of alcoholism, though vitally important, would reach few persons unless our citizens were informed of the nature of the illness and the services available through the NCARP. The position of Educational-Informational Director was incorporated into the Program set-up to take care of this area of the work. Later, as public demand for information about alcohol and alcoholism increased, it was necessary to split this

position into two separate functions. A trained journalist was employed as Publications Editor, and a professional educator as Educational Director.

Publications of the Program cover a variety of subjects related to alcoholism, its treatment and prevention. Principal among them is this journal, in which information about alcohol and alcoholism is presented in a manner which is hoped will appeal to both professional and lay people. There are available for distribution many other booklets, pamphlets, and reprints which are designed for families, schools, churches, and for alcoholics themselves.

Mass Communication

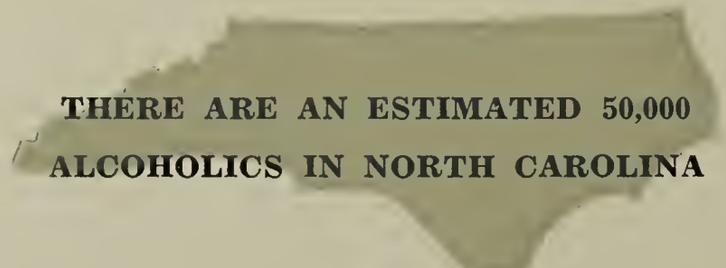
Other mass communication media successfully employed include radio, television, exhibits at fairs and statewide meetings of professional groups; and films on alcoholism, personality development, and mental health. A radio series, "Anyone You Know," produced for the ARP by the University of North Carolina Communications Center received free time on many of the State's radio stations and received an enthusiastic response. Currently in production at the University is an ARP educational film, which is especially adapted for television, as well as for viewing by group gatherings of all kinds.

ARP staff speakers appear before numbers of community, civic, and church groups to explain the work of the Program, and to promote understanding of the alcoholic and his problems. Community-wide Institutes, with leading speakers, have been held in several cities. The Program furnishes libraries of public schools and colleges with educational books on alcohol and alcoholism. In addition, ARP personnel conduct and sponsor Summer Studies on Facts About Alcohol for teachers at several of the State's teachers' colleges. Scholarships are granted each year to various professional people for attendance at the Yale Summer School of Alcohol Studies.

An important arm of the Program's education work embodies the long-range aim of prevention of alcoholism in coming generations. Some have said that prevention of alcoholism boils down to the abolition of all alcoholic beverages. This seems a simple answer on the face of it. But the Program does not feel that it is an adequate answer to the problem of prevention. Experience has shown that alcohol-prone individuals seem to be the products of poor mental health. Improving mental health practices of parents and teachers figures strongly in the work of education for preventing the illness.

Toward this end the NCARP sponsors teacher-training courses in several of the leading colleges in the State. Each course has been well attended by numbers of enthusiastic teachers who learn how to recognize and meet emotional needs of their students. They are also given objective facts about alcohol and alcoholism to convey to their young students in the classrooms.

Parents, too, come in for their



THERE ARE AN ESTIMATED 50,000 ALCOHOLICS IN NORTH CAROLINA

share of instruction about mental health. At PTA meetings, community, and church affairs where NCARP speakers appear, they learn how to improve the emotional environment of their homes—thus preparing their children to meet life's problems adequately.

What effect is this intensive effort having on the whole problem of alcoholism in North Carolina?

Results Of Treatment

Visit with us a man in a North Carolina city. Behind him is a history of ten years of uncontrolled drinking. Unemployed for five years. Family drawing welfare assistance. A friend told him about the NCARP Treatment Center, even gave the $72.00 to pay for treatment. He came home after 28 days at the Center, joined AA, went with his wife to the Mental Hygiene Clinic for follow-up treatment—and he's been completely sober now for a year and a half. He has a good job, too, and his wife and family can count on three squares a day and a good many luxuries as well. You look at this man and you think he must be the happiest man in the world. You're convinced when he tells you that he wants to get up on the roof and tell every sick alcoholic what the NCARP treatment program has done for him.

Community Helps

Multiply this case by many hundreds of grateful people throughout the State and you begin to get some idea of what this new approach to an old problem is accomplishing.

Or take a look at a small community in central North Carolina. They had been throwing their alcoholics into jail for years—and always they came back. Then some of the townspeople got hold of some NCARP literature explaining the nature of alcoholism. The word spread, and the town's attitude changed. Now, the whole town mobilizes to help him every step of the way. Pastor, banker, grocer, AA members, church members—all pitch in to help a sick alcoholic get well, and make him know they think he's worth the effort. It's no wonder that the rate of recovery in this town approaches 100 per cent.

Contrast the attitude of ten or fifteen years ago with the helpful spirit of this North Carolina town today. That's progress.

Listen to a young junior high student who finished a unit on alcohol education in his classroom. "All the kids expected the same old stuff about how drinking is a sin," he said, "but you should have seen the gang snap to attention when they found out the teacher was really laying the facts on the line." His teacher had attended one of the NCARP-sponsored Summer Schools on Facts About Alcohol. Her students and thousands of others like them in the State are now getting reliable, factual information about alcohol and alcoholism. They seem to appreciate being given the chance to decide for themselves.

NCARP personnel see literally hundreds of evidences of changing attitudes and growing interest toward the alcoholic citizen and the problems of alcohol. There is a steady flow of requests from church groups, civic organizations, professional groups,

and gatherings of all kinds for speakers on alcoholism. The Program's Education Director estimates that during last year 10,000 North Carolinians were reached through these speaking engagements. The comment of one lady, a lifelong church member, is typical of the reaction of citizens to the Program's message. "Your lecture was an enlightening experience for all of us," she says, "If every member of the community could have heard you, I am sure that our attitudes toward the alcoholic and his problems would be completely changed."

Task Just Begun

Giant strides have been made within the nearly five years of the NCARP's existence. They are encouraging, indeed. But much remains to be done. Dreams must be dreamed for the future, or the North Carolina Alcoholic Rehabilitation Program will fail to live up to its responsibilities.

Still a dream for future fulfillment is the idea of two centrally located out-patient clinics devoting full time to the treatment of alcoholics and their families. Here, former patients of the Treatment Center would get specialized help in readjusting their lives. Here, too, problem drinkers might be able to get speedy help and nip their developing alcoholism in the bud.

In order to improve the Program's services, more research is needed. The NCARP holds bright hopes that the N. C. Memorial Hospital at Chapel Hill will develop one of the country's leading centers for the study and treatment of alcoholism. The new Chapel Hill hospital has begun to accept alcoholics in any stage of the illness, and as new facilities there are opened, will expand its services in this area. The Department of Psychiatry at N. C. Memorial plans to use their Alcoholism Treatment Unit not only for research, but also to train other professional personnel—doctors, social workers, psychologists, and nurses.

In addition to projected new areas of service, the NCARP must continue to meet the growing demands of citizens for accurate information. Teacher-training programs must be expanded. Treatment must be kept abreast of the latest scientific findings. Mental health education efforts must be pushed, so that the incidence of alcoholism among our population can be steadily reduced in our oncoming generations.

All this cannot be accomplished overnight. It will require persistent effort and continuing financial support. The past five years have seen the dawn of new hope and optimism for our alcoholic citizens. Based on the progress accomplished to this point, the future looks even brighter and more hopeful.

Personality Sketches

(Continued from page 4)

couldn't sober up all the alcoholics in North Carolina." His first impulse, then was to recommend a Program with almost complete emphasis on *treatment* of the presently-existing alcoholic population. A number of experiences which followed caused him to change his mind.

Before making any recommendations to the Board, though, he turned to some of the top men in the field of alcohol problems in the country for advice and counsel. He visited Dr. Ebbe Hoff, Clinical Director of the Virginia Program on Alcoholism; went on to New York where he conferred with the famous Dr. William D. Silkworth, Medical Director of Knickerbocker, and widely-recognized for his successful treatment of al-

coholics; and finally to New Haven, Connecticut and the Yale School of Alcohol Studies, where he saw Dr. Georgio Lolli, Director of the Yale Plan Clinic, Mr. Raymond McCarthy, Executive Director of the Clinic, and Mr. Dudley Miller, Director of the Connecticut Commission on Alcoholism.

To Mr. Ruggles' surprise, he found that none of these recognized experts could offer any definite, fixed plan for attacking the problem of alcoholism. Their advice seemd to boil down to this: "There is still much we do not know about the illness of alcoholism and the alcoholic. Without public understanding and support, you face a long and probably discouraging road in getting your Program into operation. Move cautiously—but *move.*"

Long-Range Program

After his fact-finding trips, John Ruggles quickly realized, "I had a bigger job than I dreamed of." The more he learned, the more his conception of the ARP changed. It was at this point that he began to visualize a long-range Program for North Carolina which would include *education* and *prevention* as adjuncts of an immediate program of *treatment* for alcoholics.

Something that happened in Ruggles' home town of Southern Pines helped confirm in his mind the necessity for public education if an effort of this type was to be successful. The County Tuberculosis Association was sponsoring a mass chest X-ray campaign. Ruggles remembers that this campaign was preceded by a full-scale public information drive—posters blanketed the city, newspaper ads spread the word, frequent radio announcements urged cooperation. And when the big X-ray truck rolled into position on Main Street in Southern Pines, crowds of people were already lined up clamoring to get their free chest X-ray. John Ruggles drew his own lesson from this tremendously successful effort. "If our North Carolina Alcoholic Program is to be successful," he thought, "we must educate the public to accept the services which we make available."

Recommendations

After his period of consultation and reflection, Ruggles spent the better part of one night writing his report and recommendations to the N. C. Hospitals Board of Control. The report is obviously the product of a keen and dedicated mind. At the outset, he states three basic concepts upon which any consideration of the problem of alcoholism must be based. They are: (1) Alcoholism is a disease and the alcoholic a sick person; (2) The alcoholic can be helped and is worth helping; and, (3) Alcoholism is a public health problem, and, therefore, a public responsibility.

Ruggles' report recommended, among other things, the appointment of a full-time Executive Director to head the Program; provision of an intensive educational program on alcoholism throughout the State; a study and survey of the scope of North Carolina's alcoholic problem; and the establishment of a separate Alcoholic Rehabilitation Center for the care and treatment of alcoholic citizens.

Program Launched

The Hospitals Board of Control accepted Mr. Ruggles' recommendations, an Executive Director was appointed, and the North Carolina Alcoholic Rehabilitation Program was launched. Time and experience have wrought some minor changes in the Program's organization and procedures. But by and large, it stands intact today, after almost five years of operation as a tribute to the farsight-

ed, careful groundwork laid by Mr. Ruggles and the Hospitals Board.

When you look at John Ruggles' background, his leadership in the establishment of a bold new program of service to sick alcoholics is not surprising. In his Southern Pines high school annual, he is characterized as "solon of the high school," and "promoter of enterprises," among other things. In the life of his community and State, he has lived up to that early-acquired title. He has been active in almost every deserving fund-raising drive to come to Southern Pines, has been President of the Chamber of Commerce, is an active Kiwanian and member of fraternal organizations, has been a member of the Town Council and Secretary of the local Board of Elections. The Emmanuel Episcopal Church has held an important place, too, in Ruggles' affairs, and he presently serves as its Treasurer, having previously been Superintendent of the Sunday School for a number of years. In addition to all these activities, Ruggles owns and operates, with the help of his charming wife, Hilda, a busy and prosperous insurance agency in Southern Pines.

But in spite of his wide interests, John Ruggles' finds his greatest satisfactions in being a part of a movement to alleviate some of the suffering and misunderstanding accompanying the complex illness of alcoholism. He is the first to disclaim any personal credit for what has been accomplished toward this end in North Carolina. Nevertheless, the record of his pioneering effort stands. For his work, the citizens of North Carolina owe John Ruggles a lasting debt of gratitude.

IT'S MY OPINION

A Regular Feature Reserved For The Use Of Members Of A.A.

Editor's note: *All members of A.A. are cordially invited to share the benefits of their understanding and experience with the readers of INVENTORY as a public service. This page will carry the notation that the comments of the writers are their own and do not necessarily reflect the opinions of A.A. or the N.C.A.R.P. Contributions should be limited to 200 words or less. Anonymity will be respected.*

LIFE is today. "24 hours a day" is an oft repeated AA slogan. And yet I have a feeling that many of us underestimate the importance of these words.

What are you looking for in AA? In the early days, sobriety only, but as time goes on we recognize other values in life—happiness and peace of mind. But those virtues come to us only after a great deal of work. You get out of AA just what you put into it. And if you don't put anything into it, how in the hell are you going to take anything out of it?

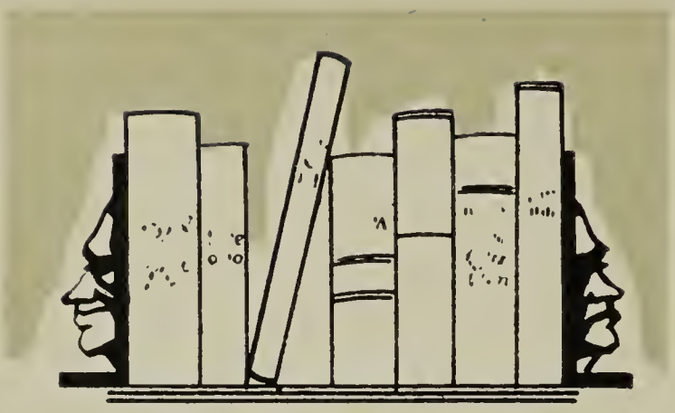
AA is a program of growth, and to me it's a program of study and living. It is something that you have to operate on a daily basis, not when we think of it. I recently read an article in which the psychologist, William Marsden, had asked 3,000 persons this question: What have you to live for? He was shocked to learn that 94% were simply enduring the present, while they waited for the future; waited for something to happen; waited for children to grow up and leave home; waited for next year; waited for another time to take a long dreamed-about trip; waited for someone to die; waited for tomorrow, without realizing that all anyone ever has is today. *Because yesterday is gone and tomorrow never comes.*

I think we in AA, who adhere to a 24-hour program, are included in the 6% of individuals who "have something to live for." You can't buy the fellowship that AA offers. I find it difficult to count my friends, and in my humble opinion they are very true and sincere friendships that have been developed over a period of time. Self-respect is something you earn, and if you stick around AA for awhile, you will gain your own self-respect. And if you are lucky, you will receive the respect of your business acquaintances, and perhaps the members of your community.

Don't sell "24 hours a day" short. Perhaps it is a trite remark, but yesterday is gone forever and tomorrow is not here. *Today is the only day that you can do anything about.* But trite or not, it is the truth, and in my opinion the secret of living 24 hours a day is our daily attempt to achieve a little humility.

To steal a friend's thunder, humility might be defined as the acceptance of truth. The opposite, of course, would consist of arrogance and pride; and pride is nothing but a lie, or an exaggerated opinion of oneself. Maybe that's why an alcoholic is so flip with the truth. A proud person finds it difficult to accept our AA program, because when he faces the 12 steps he faces truth, and truth is something he has seldom admitted. Humility is truth, and pride is a lie. Yes, when we shed the cloak of arrogance and pride, then we can begin to live just one day at a time.

—Dick C.
Robesonia, Pa.



Books of Interest

I'LL CRY TOMORROW

$3.95

By Lillian Roth

New York: Frederick Fell, Inc.

IT is not always that an author is as fortunate in the choice of collaborators as is Lillian Roth in her moving autobiography, *I'll Cry Tomorrow*. In less capable hands or told with less conviction it could have been just another True Confession Story. Instead, we are presented in the vivid, expressive language of lived experience a case history in the first person singular, having the ring of authenticity.

What is more important, we are not taken into the pit of despair and frustration and left there. Rather, step by painful step, the author takes us with her back up to a point where the tragedy is no longer to be loathed, but accepted and utilized.

Growing up for her was not a happy experience. "Looking back now," says Miss Roth, "I know that what I felt most during my childhood was fear and loneliness." Fearing her mother's displeasure, she also depended inordinately upon her not-easily-won approval, paying a high price for love. Her values had no root in self-acceptance, and her feelings of inadequacy, even at the heights of success, plagued her.

At fourteen, she was singing in "Artists and Models"; at seventeen, in Earl Carroll's "Vanities of 1928." Then came Hollywood and David, who loved her. Had he lived, this story might not have been told. Until his death, Lillian had had only two drinks in her life. The next three were urged upon her by a well-meaning friend as a desperate measure to help her sleep, when emotional and physical exhaustion brought on by her grief over his death had built up tensions that were unbearable. In these three drinks she found sleep and oblivion. From then on it became easier to find the answers with the aid of alcohol—also to create more problems for which alcohol obviously was not the answer.

Help Desperately Needed

She does not seem to have found in psychiatry the help she so desperately needed. We wonder, however, whether, as the hurt heals, and she gains new insights, she will not recognize many of them as coming from this source, and be grateful.

Miss Roth gives heart-warming testimony to the "leavening power of love" as she found it in the fellowship of Alcoholics Anonymous and at long last in the reality of a happy marriage. In giving of herself so completely to helping others, we somehow hope that she will not overshoot the mark and over-expend her resources.

In sharing with us her life, Miss Roth has done us a great service. In her triumph, our own spirits are lifted up. This book is recommended especially to non-alcoholics.

—Roberta E. Lytle
Psychiatric Social Work Consultant

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
415 Halifax St.
RALEIGH, N. C.
Phone: 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: 3-8343
Monday through Friday

Mental Hygiene Clinic
210 N. Greene St.
GREENSBORO, N. C.
Phone: 3-9426
Also at HIGH POINT
Phone: 8929
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
Chapel Hill, N. C.
Phone 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: 3-5441 & 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: 3-2471, Ext. 29
Monday through Friday

Graylyn Hospital
WINSTON-SALEM, N C.
Phone: 3-7391

FRIDAY ONLY This is purely a Clinic for alcoholics and their families. Out - patient mental hygiene clinic is located at Baptist Hospital, Winston-Salem.

Toward helping patients to re-establish satisfactory social relations all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

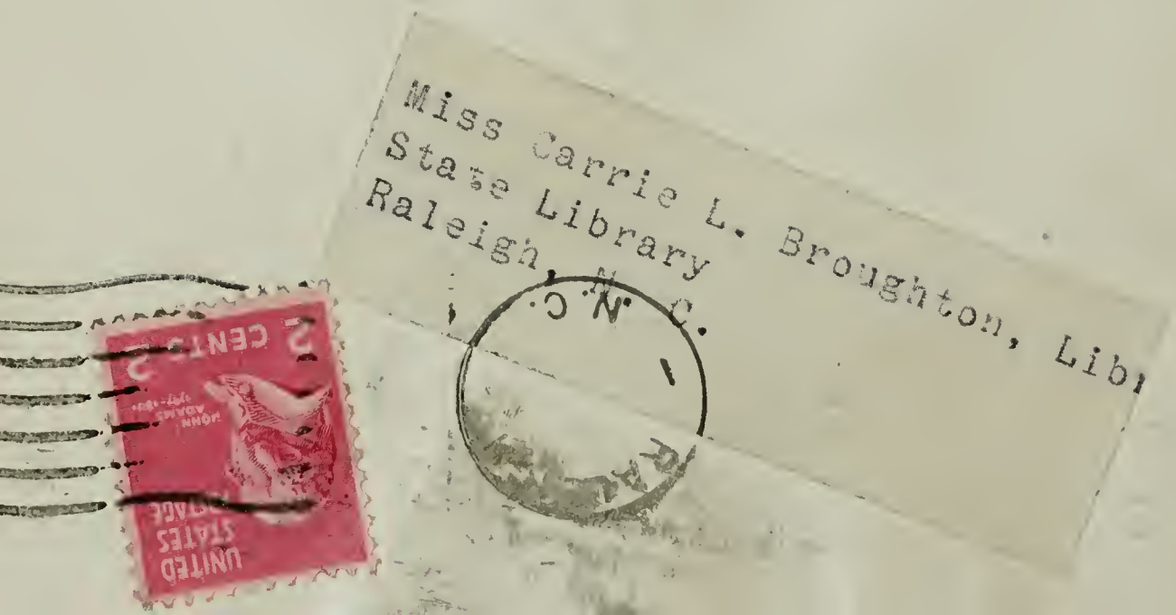
Library Kits—kits containing books and pamphlets on alcoholism. Available to libraries from N. C. Library Commission, State Library, Raleigh.

Book Loan Service—kit of reference works on alcohol and alcoholism, for high schools. Order from Education Director, 15 W. Jones St., Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
15 W. Jones St.
Raleigh, N. C.



Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

JANUARY, 1955

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, a social worker, a recreation director, and occupational therapist, and ten attendants.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.
2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.
4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illnesses. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
8 A.M. to 11 A.M. Saturday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

S. K. PROCTOR
Executive Director

NORBERT L. KELLY, Ph.D.
Educational Director

LORANT FORIZS, M.D.
Clinical Director

INVENTORY

VOLUME IV — NUMBER 5

JANUARY, 1955

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices, 15 West Jones St., Raleigh, North Carolina.

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Circulation This Issue: 16,500.

This journal is printed as a public information service. Persons desiring a place on the free mailing list must send in a written request. This journal will not be sent to persons other than those requesting it.

Write: INVENTORY, 15 W. Jones Street, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

Intelligent, Interesting Journal

Recently, someone handed me a September 1954 issue of your INVENTORY. Undoubtedly, this is the most intelligent, most interesting, and efficiently put together journal on the problem of alcohol that I have had the pleasure of reading. I would like to know if there is any possibility that sometime in the future the Oklahoma Committee could work out some arrangement whereby the materials in INVENTORY could be reprinted or used for distribution purposes by the Oklahoma Committee under our signature, with proper recognition of your organization.

Oklahoma Medical Research Foundation
Hugh G. Payne
General Manager
Oklahoma City, Okla.

Interesting And Helpful

Recently, a copy of your journal INVENTORY was sent to me by one of my AA friends and I've found it so intensely interesting and helpful that I would feel honored to be placed on your mailing list. Being an employee of the Sanatorium and secretary of the AA group here, I am always anxious to receive such fine material on alcoholism to pass on to the medical staff who are doing a wonderful job with alcoholic patients.

Name withheld

Each Issue Better

Every time I receive my copy of INVENTORY I say—this is the best issue. I want to congratulate you on the fine job you are doing. I appreciate receiving INVENTORY very much.

Wayne W. Womer
Executive Secretary
Virginia Church Temperance Council, Inc.
Richmond, Va.

Congratulations From A Kentuckian

I want to congratulate you on your splendid booklet, INVENTORY, and also on your Center for alcoholics, plus your complete program on alcoholism. I only wish my home state (Kentucky), which produces more than 60 per cent of the nation's liquor had a similar program.

O. J.
Asheville, N. C.

Minister Likes September Issue

I have usually enjoyed the rich quality of your magazine, INVENTORY, however, the September issue was tops. The short story, "The Portrait" was quite good. I appreciated the satirical humor of "12 Excuses for Getting Drunk" and was interested in the article on temperance work. Keep up the good work...

Rev. Daniel M. Schores, Jr.
Owensville, Missouri

Program Pointers

By S. K. Proctor
EXECUTIVE DIRECTOR

WHEN the General Assembly of North Carolina convenes this month it will critically review the services of all State-supported agencies, including the Alcoholic Rehabilitation Program, and will appropriate funds for the continuation or expansion of those agencies whose services seem necessary to the general welfare of the people.

We believe that the record of accomplishment by the ARP merits not only the approval of the Legislature for the continuation of the Program but also an increase in the appropriation in order that we may satisfy heavier demands on its services.

Without attempting to review in detail the progress that has been made during the past two years I would like to invite the readers' attention to what I consider the most significant steps in the forward progress of the Program.

Early in the biennium our education-information services were reorganized and intensified. A summer school study course on facts about alcohol and alcoholism designed for teachers and prospective teachers was organized at East Carolina College in 1953. It was highly successful. Consequently, we organized similar courses in the summer of 1954 at A & T College at Greensboro and Appalachian State Teachers College at Boone in addition to the course at East Carolina College. These, too, were most successful, and other colleges are asking for this service.

This magazine's circulation was under 12,000 at the start of the biennium. No names were added to the mailing list except by written request of the person desiring to receive it. The circulation is now over 16,000 and growing rapidly. We have also published a number of booklets and other pieces designed for the general public.

The patient load at the NCARP Treatment Center is considerably heavier than it was two years ago, due in part to the admission of female patients beginning in January, 1954, and in part to a more general awareness that the Treatment Center is a highly successful facility for the treatment of alcoholism.

Liaison between the State Program and out-patient services for alcoholics and their families has been vastly improved during the past year with the employment of a psychiatric social work consultant.

Other progressive steps should be mentioned, I'm sure, especially the organization of public institutes on alcoholism and literally hundreds of talks made by the clinical and administrative staffs.

Much remains to be done that should be done. The need for research continues. With funds for this purpose we could contribute much to the scientific knowledge of alcoholism from the voluminous data on file at the Treatment Center.

Keep your eyes open in the next few months for a new television series on alcoholism under the title, "Fork in the Road." Authors of national repute are cooperating in the writing of the TV films, including William Inge, author of "Come Back, Little Sheba," Tennessee Williams, author of "Streetcar Named Desire," and Charles B. Jackson, author of "Lost Weekend." Sounds promising, doesn't it? The National Committee on Alcoholism, which is serving as technical consultant, hopes that the series will be accepted for national presentation as a public service.

Are you a proud, tense, rigid person? If so, you apparently run more risk than others of becoming addicted to certain drugs. This finding resulted from a study conducted at Payne-Whitney Clinic in New York and reported in "Today's Health." There also appears to be danger for people who cannot accept their own shortcomings—which all of us have—and feel a great need to achieve community standing, wealth, and prestige. This was learned in studies of people addicted to one drug, Demerol. When denied the drug, they did not suffer much from physical troubles stemming from loss of the drug. But their personality troubles did continue. This suggests that they had a *psychological* addiction rather than a physical one.

"The cautious attitude necessary for safe driving is disturbed by small amounts of alcohol," is the warning carried in a recent issue of Oregon's *Alcohol Education Newsletter*. "The drinking driver feels braver and bolder, and is usually sure that he can drive better than usual after a drink or two. This false confidence leads him to take extra chances. Safe driving also requires quick reactions, accurate judgment of speed and distance, clear vision and good hearing. Alcohol has measurable effects on all of these functions. The combination of false confidence with impaired abilities leads to accidents, even in drivers who do not look drunk."

Another item in the same *Alcohol Education Newsletter* reports that 42 states now make some use of chemical tests to determine drunken drivers. Chemical test evidence is used according to procedures provided in the uniform code recommended for traffic law enforcement by the National Safety Council. Some states have passed or are in the process of passing a law which provides that if a driver refuses a chemical test, the driver's license is suspended on the first offense.

The New Mexico Alcoholism Commission's Bulletin reports a unique acknowledgement by one of their readers of the change in fundamental attitudes toward the alcoholic in recent years. "It's almost as if the public had adopted a new set of the three R's," the reader remarked. "Whereas it used to be 'Rant, Rebuke, and Ridicule,' now it's 'Recognize, Rally, and Rehabilitate'." If you like slogans, there's one for your consideration.

VOL. IV, No. 5 INVENTORY JANUARY, 1955

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

As alcoholism progresses, seven stages can be recognized in

THE FAMILY CRISIS

THE family of the alcoholic has been seen for the most part either as the sufferer from his misbehavior, or as the tool for his rehabilitation. But the actual fate of families caught in the crisis of alcoholism has never been studied systematically in the past. The first such study is that of J. K. Jackson (University of Washington School of Medicine, Seattle). The results of her investigation may be of decided value to all agencies which treat alcoholics or deal with their problems.

Jackson's study was limited to the marital families of men alcoholics. It was done during 3 years spent as a "member" of a women's auxiliary of Alcoholics Anonymous. Fifty women were in the group during the period of the study—all with alcoholic husbands, though not all the

husbands were members of A. A. Jackson made a stenographic record of the frank discussion of their family problems by these wives at their meetings. This record was then analyzed in an attempt to discover any similarities in the order of events, behaviors and changes. From this analysis, a picture of the families of alcoholics emerged which showed how they become involved in a growing crisis. This course, as well as the efforts to meet it and adjust to it, could be divided into seven stages:

Early Strains

Stage 1: For the most part, the early signs of excessive drinking by the husband are met by trying to pretend that no serious problem exists. Episodes of intoxication, especially if they cause social embarrassment, may strain the marital relationship, but they are easily patched up. To lessen this strain, talk about other problems of the marriage is often avoided. The wife tries to discover some "formula" by which she can deal with her husband's drinking and keep it on a respectable level. The husband stands on his rights to "drink like any man" and resents interference or any hint that he cannot control himself.

Stage 2: Attempts to deny the problem having failed, and as excessive drinking continues, some effort to eliminate it is begun—usually when the family finds itself being marked out or punished. The couple, for example, learn that they were not invited to a party; or, when they visit friends, drinks are not served, or are carefully limited. This social isolation increases the importance of inter-action between husband and wife. At the same time the importance of drinking itself becomes more intense. But talk about it is also more painful and must be avoided. Advice from relatives or friends is resented as outside interference, but the couple themselves do not know what to do.

The wife begins to feel she is a failure as episodes of drunkenness by the husband become more frequent. During periods of sobriety, the husband tries to make up for his failures by treating her especially well. But his next bout of drunkenness only magnifies the tension. Each interval of sobriety rekindles the hope that the past is past, and prevents the wife from thinking of adjusting to a husband who is an alcoholic. If there are children, they may begin to show emotional disturbance at this time.

Permanent Problem

Stage 3: In due course the family is forced to make some adjustment to a state of disorganization. The husband's drunkenness is accepted as a permanent problem. Sober periods still awaken hope—but hope weakened by past disappointments. The wife now tries mainly to relieve present tensions, to meet emergencies: she has given up trying to solve the whole problem, to "reform" her husband. When he gets drunk, the accumulated hostility between them may be allowed to find expression. They may fight openly and hurt one another, and the wife will then feel guilty for behaving in an unwomanly way.

The children may now become

(Continued on page 20)

THE BIGGEST PROBLEM

We don't have to be ashamed of problems. Everyone has them. And always the biggest problem of any individual is to live realistically.
—Camilla M. Anderson, M. D., in *Emotional Hygiene*

This company recognized the reality of alcoholism and devised a successful program for meeting it.

PROBLEM DRINKING IN INDUSTRY—

THE CONSOLIDATED EDISON PLAN

BY S. CHARLES FRANCO, M.D., F.A.C.P.
ASSOCIATE MEDICAL DIRECTOR
CONSOLIDATED EDISON COMPANY OF NEW YORK

IN December, 1947 the Consolidated Edison Company of New York officially recognized the reality of alcoholism as a medical condition. This decision was based on the policy (1) that we would meet the problem openly instead of perpetuating the outworn pretense that it did not exist. The Company Procedure on Alcoholism was adopted to provide an orderly means of achieving this objective. The aim of the procedure was threefold: (1) the early recognition of the employee with a drinking problem; (2) rehabilitation of the employee where warranted; and (3) the establishment of a consistent basis for termination of employment when rehabilitation is fruitless.

Consolidated Edison procedure defines alcoholism as the condition resulting from the immediate or past indulgence in alcoholic beverages, wherein the subject is unable to perform his assigned duties properly. From a practical point of view, in industry, we look upon "chronic alco-

(Continued on page 21)

Condensed from an article in the Yale Quarterly Journal of Studies on Alcohol,

Winston-Salem Mayor Marshall Kurfees is flanked by Harvey Dinkins and Albert S. Johnson, two members of his Committee on Alcoholism.

THIS COMMUNITY FIGHTS ALCOHOLISM

Successfully

Many local citizens and community agencies join in the work of Forsyth County's Program on Alcoholism.

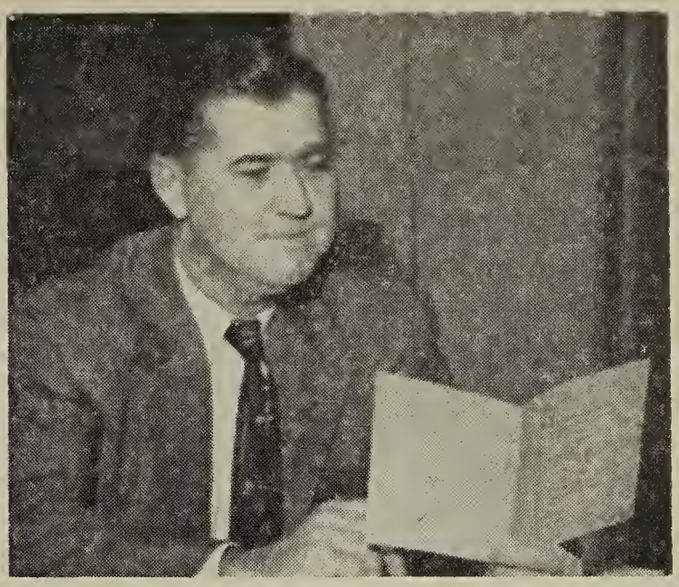
SINCE alcoholism is a community problem as well as a State problem, the answer to its treatment and prevention seems to lie in intelligent action by communities to meet the problem, bolstered by interest and support from the State level. A working example of what we mean by community action is the Forsyth County Program on Alcoholism.

The Forsyth County Program is a *local* effort in every respect. Everything about it—from the governing board to the operating funds—is stamped with a "home" label. Many people in the community have a part in its operation. All seem proud of their city-county effort to treat and prevent alcoholism at their own doorstep.

The Forsyth Program is no loosely-organized, catch-as-catch-can venture, either. Its financial support is stable, consisting of $25,000 a year of ABC revenue. Under a unique setup, this money, though appropriated by the County ABC Board, is administered by the city and county governing bodies. Thus there is no opportunity for criticism from wary citizens who

sometimes equate ABC Boards with the "liquor interests."

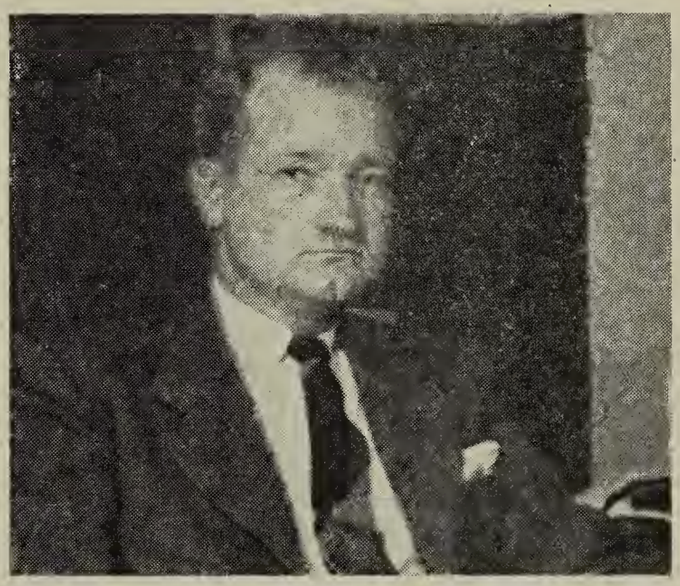
The administration and operation of the Program is sound, being staffed by professional people and backed by an Advisory Committee composed of many leading citizens of the community. As one arm of the Forsyth County Health Program, the Alcoholism Program is administered by County Health Officer Dr. Fred Pegg. Mrs. Ruth W. Haun, well-known Psychiatric Social Worker, serves as Coordinator of the Program and in that capacity has responsibility for the overall effort.



Forsyth County Health Officer Dr. Fred Pegg administers the Program.

Groundwork Laid

The Forsyth County Program on Alcoholism began operation in February of 1953. Its organizational groundwork was laid by a committee of citizens appointed by Mayor Marshall Kurfees. Mayor Kurfees served as chairman of the group, the Rev. Thomas A. Frazer was vice-chairman, and Dr. Fred Pegg was secretary. Eighteen other community leaders, including Mrs. Haun, who were interested in a scientific approach to the problems of alcoholism served on the committee. This group made a careful study of community resources, existing alcoholic rehabilitation programs, and national organizations on alcoholism. Mrs. Haun was employed as Coordinator of the developing program, and she immediately began to gather firsthand knowledge of some of the facilities for alcoholism treatment and education, including the N.C.A.R.P.



Dr. Richard C. Proctor is Director of the Alcoholism Treatment Clinic.

As a result of the variety of information gathered during this fact-finding period, the Mayor's Committee was able to sift through the experience of others in the field and to incorporate some of the best features of other programs on alcoholism into their own.

Community education is directed by Health Educator, Mr. Marshall Abee.

The Committee was encouraged by

the interest they found among the people of Winston-Salem and the surrounding county. They discovered, too, that there were a surprising number of agencies and institutions in the community which could be called upon for assistance in the overall plan of attack.

One of these institutions, the Forsyth County Hospital, was later integrated into the Program's setup as a treatment place for the acutely ill alcoholic, whose first need is for medical attention. Care for the physical needs of the alcoholic who may be seriously ill as a result of malnutrition takes precedence over any long term treatment for his emotional sickness. The great majority of private hospitals are still extremely reluctant to accept an alcoholic for this type of treatment, thus many develop serious ailments resulting from neglect. That facilities for treatment of acute alcoholism are provided by the Forsyth Program is a credit to their well-rounded approach to the problem of alcoholic rehabilitation.

Officials of the Program emphasize that "Saturday night drunks" need not apply for hospitalization, otherwise the facilities at the County Hospital would be swamped with this type of case. But if the alcoholic is really sick and wants help, and his physician will recommend admission and agree to follow his patient while he is hospitalized, he can be admitted for medical care. Wherever feasible, the patient is seen, too, by a member of Alcoholics Anonymous. Final approval for the patient's admission rests with the hospital Director, Mrs. Ruby Robinson.

The average sick alcoholic remains at Forsyth County Hospital four to five days. The fee for treatment here has been set at $8.50 per day, plus an overall charge of $10.00 for medicines. Admission doesn't hinge on the sick person's ability to pay. He may be loaned the money from Program funds, which the patient makes signed agreement to repay when he

(Continued on page 28)

Program Co-ordinator, Mrs. Ruth Haun (left) discusses admission of an alcoholic with County Hospital Director, Mrs. Ruby Robinson.

MENTAL HEALTH AGENCIES IN NORTH CAROLINA

It takes the services of many State agencies to meet the mental health problems of our citizens.

A NUMBER of State agencies in North Carolina are being granted appropriations to carry on what might be broadly classified as *mental health activities*. Principal among them are the Mental Hospitals system, the Mental Health Section of the State Board of Health, the Psychiatric Service of N. C. Memorial Hospital, Mental Hygiene Clinics, and the N. C. Alcoholic Rehabilitation Program.

The mental health movement is concerned with more than the care and treatment of persons who suffer serious mental breakdowns, important though this is. Not everyone realizes it but mental health concerns, too, the youngster who has a behavior problem, the man who cannot control his drinking, the smart boy who fails his school work, the child who is a slow learner, the young woman who is obsessed with nameless fears and anxieties. Inasmuch as all these and numerous other difficulties are symptomatic of mental ill health, they are within range of our State's mental health endeavors.

These are some of the problems which a comprehensive mental health effort must deal with and attempt to remedy. How are our State agencies approaching these problems? For the answer, let's take a brief look at the work of each of the principal agencies operating in the mental health field for which sizeable State appropriations are being expended.

The first that comes to almost everybody's mind is the State Hospitals system. These institutions are for the care, treatment, and rehabili-

(Continued on page 30)

ALCOHOLISM DRUG ADDICTION

WHAT DETERMINES TH

Dissatisfaction with oneself and environment makes a person addiction prone—but do you know why one person turns to alcohol and another prefers morphine under these circumstances?

ADDICTION to alcohol or any of the narcotic drugs seems to rest on the same inner motives: the addict is deeply dissatisfied with himself and the world around him, and feels an overwhelming need to get relief from psychic or physical pain. But why does one person turn to alcohol while another prefers morphine? Also, why is narcotic addiction condemned more strongly than alcoholism in some cultures while the reverse is true in others? What is the effect of differing social attitudes toward different forms of addiction?

J. D. Reichard (U. S. Public Health Service, Lexington, Ky.) has found three factors important in the personality of the potential addict and in the development of addiction: (1) degree of emotional or physical discomfort; (2) ability to endure discomfort; (3) strength, character and direction of internal controls of behavior.

Breaking Point

Discomfort exists in every human life. It may even serve as a stimulus to useful activity. At what point it becomes unbearable cannot be settled by any objective measure, but every personality has its breaking point if internal and external stresses become too severe.

The key factor is thus each person's capacity to tolerate discomfort and frustrations. This trait is seen to vary enormously not only between

CHOICE?

individuals but also between groups, nations or races. It can also change in the same individual with the state of his health and other circumstances. In part, this capacity can be fostered by parental and social example. In part it eludes identification. But the potential addict is certainly less able to endure discomfort of any sort than the "well adjusted" individual. The so-called normal person can tolerate most of the unpleasant experiences of daily life. He needs no chemical assistance to see him through the ordinary routine. The potential addict, on the other hand, once he has discovered the pain-reducing properties of alcohol or drugs, feels an overwhelming attraction toward this method of solving his inner tensions. It is quicker, easier and less painful than the psychologically healthier effort to attack his problems directly.

The controls of behavior operating within the individual figure importantly in this discussion. These are of two main types—one called conscience, the other called ego control. Either type, if wholesomely developed, can effectively restrict activities which might result in harm. Thus the person whose inner controls are strong and healthy is little likely to become addicted.

According to Reichard, it is the interplay of the three factors—degree of discomfort, ability to endure, and internal controls—which produces or prevents addiction once the person is exposed to alcohol or drugs. Great

discomfort, if matched by ability to endure it and with a control adequate for the situation, may allow a successful career. The person will be unhappy, perhaps hard to get along with, but he can accomplish a great deal. If the discomfort is too severe for the ability to tolerate, but controls are strong and wholesome, the result may be a chronic invalid, haunting doctors' offices, yet not addicted to any substance disapproved by his culture. When controls are inadequate or misdirected and discomfort is not well tolerated, then addiction may develop when the person is introduced to alcohol or a narcotic drug.

All that has been said thus far applies equally to the potential alcoholic or drug addict. What causes one or another addiction to be chosen?

Three Factors

According to A. Wikler (U. S. Public Health Service, Lexington, Ky.), this choice depends on a combination of three factors: (1) the individual personality; (2) the particular effects of the drug; (3) the attitudes of the society toward the various drugs. Certain characteristics, however, are common to all the substances used by addicts: they have a decided pain-reducing action; they are directly or indirectly hypnotic; they help to screen out from consciousness some of the things that cause pain or unhappiness.

But they do this in different ways. Alcohol appears to let aggression loose, whereas the opiates reduce it. A person with normally good control of his behavior may become a public menace when over-dosed with alcohol, while under opium he might remain quiet and well behaved. This difference can be explained by the fact that alcohol acts as an anesthetic on the higher brain levels first, putting to sleep the controls over the primitive aggressive drives. Opiates, on the other hand, act primarily on the lower levels of the brain, thereby weakening the aggressive drives. In the same way alcohol appears to stimulate sexual urges because it puts to sleep the nervous centers which ordinarily restrain their free expression. Opiates appear to cut sexual appetite, at least in the sense of reducing the urge for direct gratification.

Key To Choice

Whether a given individual, then, will turn to alcohol or opiates, if he has the chance to choose between them, depends in part on whether he needs a method of letting out his feelings of aggression against the world or whether he has learned to feel more comfortable when such feelings have been put to sleep.

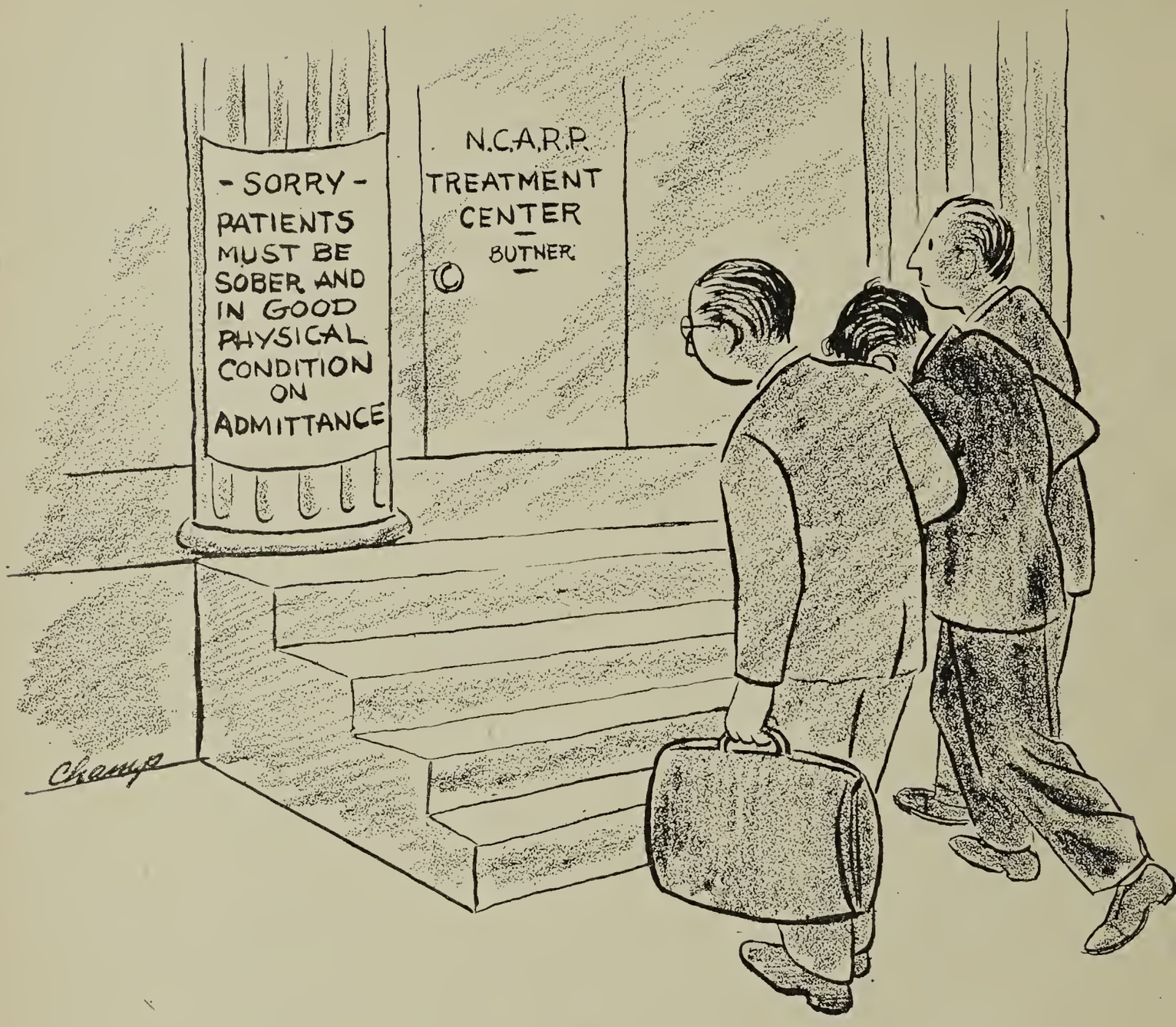
Of great importance also, in determining the choice of intoxicant, is the attitude of society. In Western culture, for instance, opium is more strongly condemned than alcohol. In some Oriental cultures, on the other hand, the reverse is true. These attitudes, Wikler points out, may be related to the different effects of alcohol and opiates. Among the Chinese, for example, a placid temperament is highly valued, while violence in any form is disparaged. Thus it is not surprising that alcohol intoxication is rare in China while opiate addiction is tolerated. In sharp contrast is the American ideal of manliness. Placidity, passivity, are not traits which American mothers nurture in their sons. Indeed, competition and rugged individualism are national ideals, and these imply a certain glorification of the aggressive instincts in man. In our culture, therefore, alcohol intoxication is often regarded with amusement. The real "he man" is supposed to be able to drink his fill and even the "fighting drunk"

is sometimes admired for his show of pugnacity. The most insidious aspect of addiction is the development of the habit of avoiding not only the particular discomfort which may have precipitated addiction but, eventually, any discomfort, no matter how trifling. Just as in the case of alcoholism, drug addiction is never definitely "cured." The disease is only arrested.

Detection and treatment of the pre-addict, before complications have appeared, should be the goal of therapists in this field. As with other personality disorders, prevention begins in childhood. Reichard believes that persons trained in childhood to have an attitude of stoicism can usually tolerate the discomforts of adult life and are less prone to addiction.

Once an addiction is fully established, treatment requires the following essentials: control of the addict for a considerable period; relief of physical dependence; removal of as many sources of discomfort as possible; increasing the ability of the patient to endure discomfort; improving, when possible, the internal controls of behavior; supplementing them for a long period with some type of supervision; correction of such complications as vitamin deficiencies; and—most difficult of all—correction of the habit of "taking something" for every feeling of discomfort or unhappiness.

Reichard stresses how much is yet to be learned about the nature and treatment of addictions. Specialists are still working in the dark. "When we can acquire a body of knowledge that will enable us to do properly for the addict and pre-addict what they are trying to do improperly, we may have solved not only the problem of addiction but many other riddles of human biology."



AN EDITORIAL

Helping the alcoholic to recover from the physical effects of excessive drinking is the first phase in his treatment and rehabilitation. Is this a responsibility of the Butner facility?

WHY THEY'RE NOT ACCEPTED

EVERY now and then a prospective patient arrives at the NCARP Treatment Center with everything in order except his equilibrium. Because he is obviously intoxicated he is refused admittance.

We can imagine the great disappointment this must be to him and to those who had been hoping and praying that the day would come when he would finally accept treatment. To have this dream shattered, even temporarily, is a terrible blow.

On the face of it this rejection of the prospective patient might seem contrary to the purposes for which the NCARP was established—to treat and rehabilitate alcoholic citizens and to educate the general public toward the acceptance of the alcoholic as a sick person who needs and deserves treatment.

Cross-Purposes?

But are we really at cross-purposes with ourselves? Some people, well-informed and well-meaning, seem to think so. In fact, they have told us that in their opinion the State should accept for treatment any alcoholic, drunk or sober, who applies for admittance to the Treatment Center.

They point out that, drunk or sober, the alcoholic is a sick person in need of treatment, and since we have State-owned facilities for treating alcoholism we are obligated to accept as patients all alcoholic citizens who desire that treatment. They say further that the ideal time to talk with an alcoholic about accepting treatment is when he is pulling out of a bender, depressed, remorseful, shaky, and perhaps tapering off. At that time he realizes that he has lost control over alcohol; he knows he needs help. Later, however, when he sobers up and has recovered from the "shakes" and other physical symptoms he is likely to feel that he no longer needs help; he feels good; he can handle it all right "next time."

The NCARP recognizes the intoxicated alcoholic as a sick person just as it recognizes the temporarily sober alcoholic as a sick person. It feels an obligation to both. The NCARP appreciates the fact that the idea of treatment is more acceptable to one shaking himself out of a bender than to one who has recovered from the physical effects of his binge. Again, the NCARP feels obligated to do what it can for both.

Fulfilling Obligations

As a matter of fact, the NCARP feels that it is fulfilling its obligations to the greatest extent of its facilities and abilities not only to all alcoholics in North Carolina but to all citizens of North Carolina—even though intoxicated persons are not accepted for treatment at the NCARP Treatment Center; even though persons on the verge of the "DTs" are not accepted for treatment there.

Three Phases

This Program is based on the principle that three phases are involved in the treatment and rehabilitation of alcoholic citizens. These three phases are too broad in scope for our facility to handle alone. Recovery from alcoholism is at best a long-term proposition requiring the combined and cooperative efforts of many specialized professional and non-professional agencies and individuals. Both the community and the State have a responsibility toward the rehabilitation of alcoholic citizens, and both benefit considerably by their recovery.

The first of these phases—and the only one under discussion in this editorial—is the sobering up period. The alcoholic is trying to pull out of a bender. He retches, sweats, and shakes. He has alternate chills and fever. He can hold nothing in his stomach, not even alcohol perhaps.

In addition he is suffering deep remorse and other mental pain. He may become delirious. One does not have to be an expert to see that this man is sick and needs medical treatment.

But is the NCARP Treatment Center the place for it? Is this really the time to start treating the emotional illness of alcoholism at the psychiatric level?

The Medical Superintendent and his medical staff at Butner do not think so. There are several reasons for this, all of them based on experience and careful consideration of the problems involved.

Physical Treatment

It has not been generally known heretofore that a number of intoxicated alcoholics were accepted at the Treatment Center back in '49 and '50, when the patient load was very light and there was plenty of time to work with the few patients on hand. They were sobered up, restored to health physically, and exposed to the personality tests, group psychotherapy, etc., but an alarming percentage of them packed their bags and headed for home shortly after their physical symptoms were relieved. We can imagine that many of them had been talked into taking the treatment while drunk or tapering off and had changed their minds when the alcoholic haze disappeared. Others might have sincerely wanted to be relieved of their compulsion to drink when recovering from a binge, admitting voluntarily that they could not handle alcohol in any form, begging for treatment, only to refuse it when placed in a treatment situation, having reconsidered the whole idea.

These patients were ready, even anxious, to accept phase number one, the sobering up period. They had expressed a verbal desire for phase number two, treatment of the emotional discomfort causing the alcoholism, but when physical health was restored they either denied the alcoholism or confidently asserted that they could stop drinking without outside help. "Surrender" to the problem would have to come later. Experience has shown that where the motivation for treatment is so slight, if present at all, the possibility of successful treatment at the Center is extremely remote.

The sobering up situation could have been handled more conveniently and just as well by any local physician and/or any local general hospital. The rub, of course, is that many local physicians and general hospitals do not accept patients on a diagnosis of acute alcoholism. This is regrettable, but the fact remains that the professional personnel and the facilities for treating acute alcoholism are present in almost every community in the State.

Local Acceptance

The Executive Director has been trying to sell this idea to the administrators of general hospitals since 1949, asking them to cooperate with our efforts to treat and rehabilitate alcoholic citizens. The medical staff at Butner have urged general practitioners to help restore the physical health of alcoholic citizens who desire that service. Articles in this publication have also importuned local physicians and hospital administrators about this. At this time we are not sure how much progress has been made, but we know that many local doctors and local hospitals are now accepting alcoholic patients that did not previously do so.

Other reasons why the medical staff does not feel that the Treatment Center should accept physically ill alcoholics include the tremendous cost involved in employing additional physicians, nurses, attendants and

making additional beds available. Actually, it would be a duplication (at the taxpayers' expense) of facilities and personnel now available in practically every community in the State.

The Treatment Center is located at Butner, near the northeast center of the State, and its patients come from every section of this long, narrow State. If the Center were to provide sobering up services it seems reasonable that most of the 'sobering up' patients would come from nearby communities, and this would be an unequal distribution of its services to all of the State's citizens.

But the medical staff is of the opinion that motivation is the most important consideration in the acceptance or rejection of intoxicated or physically ill patients. It has been established by practically every treatment facility in the country that an alcoholic cannot be relieved of his compulsion to drink until he accepts emotionally as well as intellectually the fact that he has lost the power of choice in the matter of drinking and is willing to cooperate with the people who can help him to adjust happily to life situations without the crutch of alcohol. It is impossible for them to be sure that this kind of motivation is present when the patient is intoxicated or suffering from the after-effects of a drinking spree.

Only when the patient is properly motivated to achieve lasting sobriety and peace of mind can the Treatment Center begin its investigation into the causes of his illness and give him a basis for recovery. That is the purpose of the NCARP Treatment Center. The record indicates that it is serving its purpose well.

Please Note

FEE OF $75 NOW REQUIRED TO ENTER NCARP TREATMENT CENTER

Effective January 1, 1955 the fee for admission to the NCARP Treatment Center at Butner is increased to $75 for the 28-day treatment. This is a $3 increase over the previous entrance fee and is due to increased costs of operation. It is the first increase in the admittance fee since the Butner facility began operation in 1949.

Persons desiring treatment at the NCARP Treatment Center are required to pay the $75 fee in cash or certified check on admission. Other entrance requirements are listed on the inside front cover of this magazine.

The Family Crisis

(Continued from page 6)

severely disturbed. They have probably learned what the true situation is, but they are divided in their loyalties. Father is very good to them when sober.

In this stage, the family's self-sufficiency is likely to become disrupted. The husband may get into trouble with the police—perhaps land in jail. An emergency may occur in which the wife is finally forced to seek outside help—the police, or a social agency. Relations between husband and wife are not improved by her recourse to such help.

Wife Becomes Family Head

Stage 4: As the disorder progresses, the wife is forced to take over full control of the family. She tries to reorganize it on the basis that her husband is helpless. She becomes actual head of the family, treating the husband as another child. She assumes responsibility for the household expenses, control of the children, and care of the husband. He may show resentment of this change, especially where the children are concerned, and try to get them to side with him against the "bossy" and "inconsiderate" mother.

The family thus becomes more stable, but it still suffers from disorganization: The man's pay checks tend to become smaller and less regular. He is liable to accidents and illness. His behavior may become more violent or more bizarre. He may need hospitalization. The wife is likely to get acquainted with more and more agencies of help, and the husband may talk of doing something about his drinking.

Stage 5: The episodes of drunkenness do not stop, however, but occur oftener, last longer, and are more disastrous for the family. Finally the wife decides to cut the problem by ending the marriage. If she has by now gotten the family on an orderly basis in spite of the husband's alcoholism, this decision may be easier for her. She may just separate from her husband, or she may divorce him. Often this step will follow an exceptional crisis, as when the alcoholic husband has tried to do violence to her or the children, or has done something to bring them into public disgrace. Sometimes it is provoked or eased by the husband's desertion. But in other cases the separation has the effect of sobering the husband up, at least for a time, and the family may be reunited.

Actual or formal separation may be avoided, however, and Stage 7 may be entered instead.

Family Without A Husband

Stage 6: Separation from the alcoholic husband results in partial reorganization of the family—as a unit without a man at the head of it. The situation is similar to that in other divorced or separated families, yet in some respects it is not quite the same. Relationship with the husband is not quite cut off. The wife may feel guilty over having deserted and cast out a "sick man." The husband may enter a period of good behavior and work on the children to recapture their loyalty; or, when he gets drunk, he may endanger the wife's job by calls at her place of work. The familiy is partly reorganized, but it is not through with the alcoholic and the problem of alcoholism.

Stage 7: This stage is reached if the husband's alcoholism is arrested, whether through Alcoholics Anonymous, medical and social treatment, or by whatever means. If the family

was broken up, it is now reunited. But the problems of the family are not entirely over just because the man has really given up alcohol and is sober.

Every marriage and every family has its internal troubles. While the husband was an alcoholic, this problem dominated the scene. All difficulties in the family came to be blamed on the alcoholism, and no adjustment was made to the other problems. Now it turns out, naturally, that the former alcoholic was not an "ideal person" even aside from alcoholism. It is not easy, at this late stage, to adjust to his non-alcoholic faults.

Other problems arise, connected with the change in the situation. The wife has become used to running the family. The children are accustomed to looking to her for decisions. The man, of course feels he should now be consulted. But he is almost a stranger; the family is far from sure he can be trusted and relied upon. The husband may devote a great deal of time to helping alcoholics, feeling this is necessary for his own continued recovery; but the wife may resent his devotion to them instead of to her—after all she has gone through. She may even resent the fact that others succeeded in saving her husband where she could not. These problems in Stage 7 must be met and solved if the family as well as the alcoholic is to recover. The wife's membership in an A.A. auxiliary is especially helpful in this respect.

E. M. Jellinek pointed out the importance of the phases of alcoholism. Recognizing the phase of alcoholism a patient has reached enables the therapist to deal appropriately with him. Jackson has now pointed out the importance of recognizing the stages of alcoholism as a family problem. The therapist or agencies dealing with the wife or family of the alcoholic can likewise plan their help on more practical lines if they first determine the stage of family crisis: whether the situation is in an early stage of its evolution—where the true nature of the problem is hardly recognized or admitted—or in a later stage when, for example, the wife may be minded to break up the marriage.

The Consolidated Edison Plan

(Continued from page 7)

holism" and problem drinking as one and the same condition, and both terms characterize the situation where repeated or continued overindulgence interferes with the efficient performance of an individual's work assignment. Since a certain percentage of these individuals are not real alcohol addicts, they are more accurately described as problem drinkers.

The Medical Department also considers as problem drinkers those patients whose chronic excessive drink-

BODY ENGLISH

A BOUNCER in a beer parlor threw a free-lunch moocher out four times running, but the undaunted victim kept staggering back for more. A customer watched the performance with unflagging interest and finally tapped the bouncer on the shoulder. "Know why that bum keeps coming back in?" he observed. "You're putting too much backspin on him."

ing produces a medical complication, such as cirrhosis of the liver or neuropathy. Both the medical and the administrative approach are designed for the early recognition of problem drinking, but when any company enters upon a program it is usually the most advanced cases that are recognized first. This certainly was our experience at Consolidated Edison. We realize that earlier recognition of problem drinking is needed to achieve the best results from treatment. This is dependent largely on the recognition of the "hidden man," as outlined by Henderson and Bacon, by those closely associated with him before he becomes an advanced alcoholic.

Under our Company procedure, the foreman and the supervisor are considered to be in the best position to recognize the early signs of uncontrolled use of alcohol among men working under them. It is not the responsibility of the Medical Department to discover alcoholics. In fact, it would be detrimental to the doctor-patient relationship to place the Medical Department in such a role. Of course, the supervisor and foreman should receive some type of organized instruction to enable them to understand the objectives of the Company procedure and to assist them in recognizing the earliest signs of problem drinking. Certainly they should be acquainted with the "hidden man." As we look back we realize that this phase of education was delayed and probably should have been given in the first or second year rather than in the sixth year of our program. However, experience is the best teacher and we have come to recognize the following signs as indicative of the early phase of a drinking problem and often characteristic of the "hidden man."

1. Consistent tardiness or absence on Monday morning and frequent occurrences of leaving early on Friday afternoon.
2. Unexplained disappearance from an assigned post during a tour of duty.
3. Recurring excuses for absence due to minor illnesses, such as, "colds," bronchitis, stomach upsets, or too frequent off-duty accidents, particularly with assault as a factor.
4. Personality change in a previously good worker; such as, arguments or criticism of others, recurring mistakes for which he defends himself, minor accidents which he blames on others or on equipment, marked variation in mood, and disinterest in his work.

In our Company the Industrial Relations Team has the responsibility for the training program and the Medical Department acts in an advisory capacity. The benefits of this training have been noted in the increased number of cases with a drinking problem which were recognized on the job.

Recognition

It is axiomatic that without a definite company procedure on alcoholism, management cannot have any accurate knowledge of the extent of the problem. The stereotype alcoholic is easily recognized but is rarely found working on a regular job. More often the results of problem drinking in industry are masked by being attributed to other causes. The unfitness of the problem drinker is consciously or unconsciously "covered up" by his fellow employees, his union steward and his foreman. Even higher executives may be prone to close their eyes to a problem if they do not know what to do about it. Some of these problem drinkers masquerade under other categories of illness and reach the pension roster

where they are classed as disabled by chronic disease which is in reality but a complication of their fundamental trouble: alcoholism. This circumstance has given rise to the erroneous concept in some quarters that alcoholism need not be considered a problem in industry.

We realize that statistics as to the incidence of alcoholism in industry vary a great deal. Our own experience, over the past 6 years, leads us to place the annual incidence of new cases at about 1½ to 2 cases per 1,000 employees per year. In each year we averaged between 40 and 45 new cases with a drinking problem. In 1953 the rate was higher, possibly as a result of the supervisory training program mentioned earlier, and 61 new cases were recognized in that year. The total number of cases in the period from January 1, 1948 to December 31, 1953 is 258, or slightly over 1 per cent in our group of approximately 25,000 employees. By contrast Jellinek and Keller have estimated the rate of alcoholism in the total adult population of the New York area at about 5 per cent. There is reason to believe that the real incidence in industry is probably at least 3 per cent, for cases of problem drinking are "hidden" even in companies with an alcoholism program.

The actual operation of the Consolidated Edison Company's "Procedure on Alcoholism" is as follows: When any department of the Company is confronted with a behavior problem arising from repeated alcoholic excess, the employee is first interviewed by his immediate supervisor. The union shop steward may be present at the time. The employee usually has had a preliminary warning on a previous occasion. This preliminary warning is always incorporated in the employee's record.

First Offense

Persons employed for 2 years or less may be discharged for the first offense. Offenders with more than 2 years' service are placed on probation. At this stage, the employee is known as an "A" case. The situation is called to his attention and he is warned as to the consequences of a repetition of the offense. The employee is advised that he is being referred to the Medical Department for the purpose of evaluating his medical condition and determining if rehabilitation measures should be undertaken. He is further advised that information given by him to the examining physician may not be treated as a privileged communication. This is necessary because we may later wish to present all the facts at a panel review so that the true picture of the individual is presented in its entirety. Experience has shown that this often results in a more sympathetic understanding of the em-

ployee's problem by the lay members of the panel and adds to the understanding of alcoholism by all levels of supervision concerned.

As the second step in the process, the department head notifies the Personnel Director and furnishes him with a written report of all the circumstances. The Personnel Director then requests an examination of the employee by the Medical Department, to which all the information at hand and on file is forwarded. We are convinced that a complete and detailed report giving the entire story is of tremendous assistance to the physician in making his evaluation of the case. On the other hand, a report covering only an isolated incident of drinking is of little value. The employee may be reluctant to recount his story to the examining physician, but in discussing his version of the circumstances in the supervisor's report, the employee can give a fairly accurate picture of his real situation.

Brief Report

Upon completion of the examination the Medical Director renders a report to management through the Personnel Director. At this stage, the report is very brief and only indicates that the individual fits into one of three categories; alcoholic, questionable alcoholic, or not an alcoholic. It also states whether he requires physical restrictions because of his alcoholism. If the Medical Department confirms that the employee has a drinking problem, he is offered the opportunity for rehabilitation through Company facilities. On the other hand, he may choose to try Alcoholics Anonymous or place himself under the care of a physician of his own choice.

If the offense recurs after these steps have been taken, the employee is suspended by his department. At this stage he is known as a "B" case. At the time of suspension, a panel for adjudication of the case is convened at the earliest possible moment. This panel includes a representative each of management, of the Personnel and Medical Departments, and the department which employs the individual. At this stage, the Medical Department's report is detailed and conveys medical information that might in other circumstances be considered confidential. It will be recalled that the employee, in his interview with his immediate supervisor, had been advised that information he conveys to the examining physician may not be considered as a privileged communication. In actual practice this has proven of great value to the employee concerned because it allows the Medical Department to present the train of circumstances which caused the relapse and, at times, has been a factor in the decision of the department to give the employee a "second chance."

After all information has been presented and evaluated the department renders its decision. This is discussed and reviewed by the whole panel. Final action is then determined in accordance with established procedures just as in other cases of medical or related disability. While alcoholism is treated as a medical condition, it receives no disproportionate share of attention. Some critics have suggested that the existing procedure is a reward for misbehavior. On the

Alibis are just about as useful as a glass eye at a keyhole.
—From *The Grapevine*

contrary, means are provided in the procedure to discipline the occasional offender, the person who has no underlying medical or psychological reason for overindulgence. The average age of those acted upon by the panel has been 49 years and the length of service 22 years. Of those whose services have been terminated by panel action, 33 per cent have been granted disability annuities and the remainder have received disability allowances limited as to duration. A few have been discharged for obvious misbehavior.

Two Periods

Our experience under the Procedure on Alcoholism can be divided into two periods; first, from January 1, 1948, to December 31, 1951, and second, since January, 1952, the facilities of the Consultation Clinic for Alcoholism having become operative early in that year. The first period was definitely a step in the right direction, but it did not go far enough. Under the Company procedure there developed not only an orderly approach to the problem of alcoholism but, in addition, the program had real merit in that it brought forcibly to the attention of the alcoholic employee the fact that drinking was creating a problem for him. The major shortcoming of the program in the first period was that medical facilities for adequate treatment were generally not available. The majority of the employees involved seemed reluctant to enter Alcoholics Anonymous. Perhaps this was due to lack of an organized A. A. program under Company sponsorship. Some individuals derived great benefit from A. A. but these were few in number.

Our follow-up experience to this date, March 1, 1954, on the original group who were treated under the first phase of the alcoholism procedure in the 4 years from January, 1948 to December, 1951 can be summarized as follows: There were 155 cases in the group of which 11 were subsequently referred to the Consultation Clinic. For the balance of this group the "recovery rate" has been 69 out of 144 cases, or 48 per cent. It should be emphasized that the majority of these cases have been followed more than 5 years and the shortest period of observation has been more than 2 years. We have also learned from other sources that a few of the employees who left the Company rehabilitated themselves later through other agencies, particularly A. A., and are now gainfully employed.

Logical Answer

As we reviewed our experience it became apparent that a special center for the medical treatment of alcoholism was a logical answer to the problem. In any one company the number of known cases did not justify the cost of establishing an inside clinic for the study of this condition and we felt that industry should pool its resources in an outside special center. Convinced by the lessons of its own internal program of the need of such a center, top man-

agement at Consolidated Edison in December, 1951 volunteered to underwrite the cost of launching a Consultation Clinic for Alcoholism at the University Hospital of the New York University-Bellevue Medical Center. This clinic, the first to be devoted solely to the alcoholic in industry, was developed with the guidance of Dr. A. J. Lanza, Director of the Institute of Industrial Medicine, New York University-Bellevue Medical Center, and was formally opened on February 4, 1952. The Standard Oil Company of New Jersey joined in the use and support of the clinic facilities in October, 1952. Since then 10 other companies have taken the opportunity to refer occasional drinking problem cases to the clinic. In February, 1954 the Consolidated Edison Employees Mutual Aid Society, Inc., continued the contribution that had been initiated by the Company in the previous 2 years.

Types Of Patients

It has been our policy with respect to the Consultation Clinic that the patient be referred only through the Medical Department and, of course, always with his consent. There are three types of patients who have been sent to the Consultation Clinic. One, and this is the largest group, comprises those coming under the Company procedure. Two, where alcoholism is considered by the Medical Department physician to be a contributory factor in a medical problem. Three, those employees who realize that drinking is causing a problem in some phase of their everyday life though not as yet interfering with their job performance.

Approximately 25 per cent of the patients gladly accept treatment and demonstrate "surrender phenomena" in acknowledging that they have a problem with drinking and that they desire help. A very small number, less than 5 per cent, refuse any treatment. The remainder initially appear to submit to treatment because they are motivated by the desire to hold on to their jobs, which are in jeopardy when they are placed on probation under the Company procedure. We were interested in observing, on follow-up, that about half of these, between the third and sixth month of treatment, begin to realize the nature of their problem and reach that acceptance of treatment which apparently is essential to successful rehabilitation. About 15 per cent abandon treatment and some seemingly continue to avoid difficulties with drinking, but the majority of those who discontinue treatment either suffer a relapse and are separated from the Company or resign their position. In the group that drop treatment early there is a high percentage of "medical referrals," i.e., those who have not come under the Company Procedure on Alcoholism. It adds to our conviction that the precipitation of a crisis under the Procedure is the best stimulus to successful rehabilitation.

The big question about rehabilita-

THE HIGH COST OF EDUCATION

The wealthy aunt, paying her nephew's way through college, was asked by a friend if such an undertaking was expensive.

"Well," she replied, "many subjects aren't every dear, but the languages run rather high. For instance, this term it cost $12 for chemistry, $15 for mathematics, and $150 for Scotch.

—from Chit-Chat

tion is, "How shall we evaluate the results?" We know that analysis of the results of rehabilitation is a long-term affair. We feel that one cannot speak even of "social recovery" until the completion of at least a full year of observation and preferably 2 years. It is our policy, therefore, to set probation tentatively at 1 year with the understanding that it is really for an indefinite period. Since the employee is denied progression and merit pay increases during the period of probation, we limit it to 1 year to provide an incentive for rehabilitation and reward for his efforts. It would be poor psychology to extend this period officially. However, any relapse after the 1-year period still brings the individual under the "B" procedure and requires review by a panel. Theoretically, we should consider that recovery is complete only after 4 years of uninterrupted total abstinence.

In the past 2 years we have referred 105 cases to the Consultation Clinic at the University Hospital. Initially, taking the groups in each calendar year, the results appear deceptively good: there were nearly 80 per cent "improved" in 1952 and 1953; but when the period of observation is extended beyond a year we obtain in each case a more accurate picture of our progress. Of the 59 cases who have completed more than a year of follow-up, 37 (63 per cent) appear to have their problem under control. Of these 37, 26 (70 per cent) have completed 1½ years of treatment, and for some it is nearer 2 years. The deficiencies of this relatively brief follow-up are apparent but the trend is very encouraging because the greatest percentage of losses appears to occur in the first year of treatment. The results of treatment at the Consultation Clinic have been an improvement on our previous experience. We have not only salvaged employees that we otherwise would have lost but case absenteeism has been greatly reduced. Since the inception of treatment the absenteeism rate has been less than 4 days in the rehabilitated cases.

Three Objectives

As we review our experience under the Company Procedure on Alcoholism, we realize that such a program entails three objectives which, indeed, are interrelated: (1) Recognition, (2) Rehabilitation, and (3) Prevention. We feel that we are now on the threshold of that phase of the program in which we might consider steps to prevent the development of problem drinking. The first step in prevention was actually taken when Management placed the Alcoholism Procedure in operation. The second step was the establishment of the Consultation Clinic, which improved the means of rehabilitation. These are essential, though preliminary, steps in a total preventive program. This brings us to the third step: education.

The phase of education on problem drinking has to be entered upon slowly and its success is based largely on the good results of a program actually in operation. If a large-scale

educational effort is launched prematurely it might defeat the entire purpose of the program. From a practical point of view, at present we have to depend on those working with the problem drinker or his own family to bring the problem to his attention. The training program, to explain the working of the Company Procedure on Alcoholism and the results of the rehabilitation program to the supervisory employees, resulted in an increase in the number of cases recognized on the job. A training session from this program was also presented to the business agents and other officials of the Union at their request. The advice of the Union stewards has at times caused an employee to seek help for his problem. Our next step in education should be with the rank and file employees and their families, but we feel that this should wait until we can garner more experience with the operation of the Consultation Clinic. Part of this program of education may be based on previously tested techniques, and through media such as employee publications, motion pictures, lectures and posters, but there is need for a more personalized approach to the individual himself.

It is worth repeating what various spokesmen for Consolidated Edison have said for the past 4 years: "We suggest that industry, through such a plan, can make a determined effort to help the problem drinker overcome his handicap and, where successful, receive in return not only the savings which increased efficiency and decreased absenteeism bring, but also salvage the skills and experience of an employee acquired through years of service."

This Community Fights Alcoholism

(Continued from page 10)

is able. The hospitalization facilities as well as all the other facilities of the Forsyth Program are open to male or female of any race or color.

After the patient improves physically he is then ready to consider some long term treatment for his emotional illness. Here, Mrs. Haun uses her skills as a psychiatric social worker to explain to the patient some of the possibilities for treatment which are open to him, and to help him understand his need for treatment. Only about half of the Clinic case-load needs hospitalization for medical treatment, but Mrs. Haun sees *every* patient for one or more interviews to map out the various treatment routes.

Facilities For Treatment

What are some of the facilities for further treatment which are within range of the alcoholic in Forsyth?

First, there is the Program's Alcoholism Clinic, providing out-patient treatment services. Dr. Richard Proctor, psychiatrist on the staff of Graylyn Hospital serves the clinic on a part-time basis, and Mrs. Haun is the full-time psychiatric social worker. Treatment periods vary, and the patient may continue in therapy for as long as he and the clinic staff feel is necessary for continuing sobriety.

Treatment at the N. C. Alcoholic Rehabilitation Center is another

The experience of yesterday, the opportunities of today, and *faith* in the possibilities of tomorrow, constitute the foundation of a better way of life.
—From *The Grapevine*

possibility which is thoroughly explained to the patient. If he decides to go there, Mrs. Haun sets the stage by explaining the type and purpose of treatment and then takes the patient's complete social history for use by the staff of the Treatment Center. If the patient is unable to pay the $72.00 fee for admission, he may again borrow from the Program's loan fund. Following treatment at the ARC, a sizeable percentage of Forsyth patients and their families return to the County Clinic for out-patient therapy under Dr. Proctor and Mrs. Haun.

Alcoholics Anonymous, too, plays an important role in the overall Forsyth County treatment program. A panel of five AA members is on call round the clock. Mrs. Haun may call on them to help get a patient sober enough for admission to the County Hospital, or for other assistance. Many patients who come to the Clinic eventually find their way to sobriety and happiness through Alcoholics Anonymous. No matter what the request, the Forsyth Program has found local AA members always ready to render effective help.

Other Facilities

Other facilities in the area which can give professional assistance to the alcoholic and his family include the Baptist Hospital, the Veterans Administration, and the Graylyn Out-Patient Clinic. Any patient who comes to the Forsyth Clinic for help may decide on none, only one, or a combination of several of the existing treatment facilities. The important thing is that the patient decides, free from any coercion from the Clinic staff.

How do alcoholics and their families find out about the Program's services? Public education is the answer. The Forsyth County Program doesn't place all its emphasis on treatment. Equally important is their education-prevention effort. Until recently, this arm of the work has been handled by Mrs. Haun, with assistance from the Clinic Director, Dr. Proctor. When it became obvious that public demand for education services was far exceeding the Clinic staff's ability to meet it, Mrs. Haun applealed to County Health Officer, Dr. Pegg, for assistance. As a result, a graduate Health Educator, Mr. Marshall Abee, was employed and is now devoting a portion of his time to community education projects on alcohol and alcoholism.

Educational Activities

The Program's educational activities have included film-illustrated talks before various community groups, distribution of alcohol education materials and mental health literature to teachers, placement of book kits on alcohol and mental hygiene in all community libraries, and placing of exhibits in all schools in the area. The new Health Educator, Mr. Abee, will continue all of these activities, and in addition, has plans for intensifying the educational endeavor. Topping his list of future plans is a television and radio series on mental health and alcohol, already scheduled for daily time on a Winston-Salem station.

Of course, all the work of the Forsyth County Program is aimed ultimately at prevention. But an arm

If clinical services were available to those who need them, the psychiatric clinics would be treating 2,500,000 a year instead of 250,000.

—Dr. George S. Stevenson, Medical Director
The National Association of Mental Health

of the venture which perhaps holds great encouragement for preventing alcoholism and other emotional illnesses in future generations, is the traveling School Psychological Clinic, which is supported by funds from the Program. Directed by Dr. Joseph R. Grassi, chief of clinical psychology at Bowman-Gray Medical School, this clinic detects many cases of early emotional maladjustment in school children. These incipient disturbances, if allowed to continue unchecked might give rise to alcoholism or other emotional illnesses in adult life.

Treatment, education, rehabilitation, prevention—the cornerstones of the N. C. Alcoholic Rehabilitation Program—are likewise embodied in the locally operated Forsyth County Program on Alcoholism. As a realistic, scientific approach to alcoholism and its accompanying problems, this Program furnishes a working model and a challenge for other communities. The Forsyth Program will in February celebrate its second anniversary. Perhaps by the time their third anniversary rolls around, there will have been other North Carolina communities to join Forsyth in the job of treating and preventing alcoholism at home. Right now, the Forsyth Program stands alone—in the forefront of a challenging field of endeavor.

North Carolina's Mental Health Agencies

(Continued from page 11)

tation of those persons suffering from the more incapacitating mental illnesses, often requiring long-term hospitalization. Facilities within the Hospitals system are also provided for custodial care of unmanageable senile cases, the mentally retarded, the criminally insane, and severe epileptics.

Recently, a bond issue of 22 million dollars for improvements within the State Hospitals system was approved by vote of the people. This money has been allocated to the building of a school for feeble-minded Negro children, an Admissions and Hospital building for the State Hospital at Morganton, a school for white feeble-minded children at Morganton, and to other needed additions. Completion of these facilities will fill a great need in the State. But we haven't in any sense arrived at perfection in our State Hospital services. Certainly, buildings and beds are necessary. Figures show that over the past six years State Hospital population has steadily increased, and the trend shows no likelihood of reversal within the near future.

Personnel Problem

But important as fine new buildings are, they must be staffed with capable, trained personnel if they are to fulfill the purpose for which they were built. As a matter of fact, all State institutions are presently critically under-staffed. Personnel needs must be met in order that treatment efforts may be intensified and the total time lapse between admission and recovery can be cut. We do not point this out to detract from the magnificent progress made up to this point in providing more adequate hospital facilities for those with mental illness. Rather, to call attention to the need for continuing support for this area of our mental health effort.

The North Carolina Memorial Hospital at Chapel Hill is a State supported institution. It includes among its services a psychiatric wing for hospital treatment of mentally ill patients. The critical eye might view this as evidence of duplication by

N. C. Memorial of services offered by the State Hospitals. A closer look at the Chapel Hill operation, however, reveals a difference in emphasis between it and the State Mental Hospitals, which are devoted almost exclusively to long term hospitalization or custodial care.

The N. C. Memorial Psychiatric Wing, on the other hand, accents *training* of professional personnel and research into the causes and development of emotional illness. To carry out this dual function, it is necessary to have patients on their wards in whom the dynamics of emotional illness may be observed and studied. This is not to imply that patients are used as "guinea pigs." They receive the very latest and finest treatment available. But at the same time their treatment and progress in the hospital, their entire case histories are used to provide study materials for young professionals and to improve psychiatry's skills and techniques.

One especially unique function envisioned for the Chapel Hill facility, in addition to the training of psychiatric personnel, will be the job of orienting persons from the non-psychiatric professions—nurses, general practitioners, ministers, and the like—helping them to recognize and deal with symptoms of mental ill-health. A widespread orientation of non-psychiatric persons will, it is hoped, relieve the psychiatric professions, currently in short supply and badly overworked, of some of the pressure of bulging case loads.

Important in the total mental health picture in North Carolina is the State Board of Health's Mental Health Section. Its principal function is the Administration of funds for the support of six community Mental Hygiene Clinics. These clinics help to prevent the development of some of the more serious mental disorders, through early detection and treatment of emotional illness in children and adults. Treatment at the clinics differs from hospital treatment in that it is on an out-patient basis. Under this kind of treatment setup the patient may remain at his work or at school, and maintain his home and community ties while he gets regular treatment from the Mental Hygiene Clinic's psychiatrist and his treatment team. Through this type of out-patient treatment, many serious mental illnesses are averted.

Appropriation Needed

The present six Mental Hygiene Clinics in North Carolina are not adequate to meet the needs of our population for this kind of service. The Mental Health Section has as its present goal the establishment and partial support of ten regional mental health centers, one each in Asheville, Charlotte, Durham, Elizabeth City, Fayetteville, Greensboro, Greenville, Raleigh, Wilmington, and Winston-Salem. For the establishment of this expanded program, the Mental Health Section is asking the Legislature for an appropriation of $380,000 for the years 1955-57.

Aside from treatment, the projected Mental Health Centers would pro-

vide consultation service to doctors, ministers, social workers, and mental health nurses; and participate in community mental health education.

The establishment and support of Mental Health Centers is not all of the Mental Health Section's program. It pays the salary of a Mental Health Consultant with the School Health Coordinating Service. It is his job to consult with teachers in the public school system on their pupils' emotional problems, and to conduct training institutes for teachers. In addition, the Mental Health Section conducts institutes for Health Officers, and holds in-service training courses for professional people.

The North Carolina Alcoholic Rehabilitation Program provides services for the treatment and rehabilitation of still another segment of our emotionally ill population. It carries on an educational program, too, aimed at reduction in the incidence of this particular illness—alcoholism. Since alcoholism is regarded as a symptom of emotional illness some may wonder why it cannot best be treated in our State Hospitals.

Committed Patients

The fact is, experience has shown that the majority of alcoholics will not take advantage of State Hospital treatment facilities. Most alcoholics are extremely wary, some even resentful, of any suggestion that they be hospitalized along with psychotic patients. Of course, facilities for committed patients are still maintained at the State Hospital in Raleigh. An occasional alcoholic feels that he cannot trust himself for the kind of voluntary treatment offered by the Alcoholic Rehabilitation Program and will insist on commitment to the Raleigh Hospital instead. But to the majority of alcoholic patients, treatment facilities devoted exclusively to them and their families are much more appealing than enforced confinement in a State Hospital. They are more responsive to treatment designed especially to meet their needs, and their chances for recovery are thereby improved.

The NCARP's extensive education-information program embodies the mental health approach, but it is directed toward one specific goal—the steady reduction of cases of alcoholism in the State. Poor mental health may evidence itself in a number of symptoms, but only alcoholism claims the attention of the NCARP. Always with *prevention* as the objective, the Program's education arm spreads factual information about alcohol, alcoholism, and explains the relation of alcoholism to mental ill health.

Results Encouraging

Results of the Alcoholic Rehabilitation Program's efforts have been encouraging. Some 1700 of our alcoholic citizens have received treatment at the Alcoholic Rehabilitation Center. Thousands of people over the State have gained new knowledge about the nature of the illness. But reliable estimates place the alcoholic population of North Carolina at around 50,000. It seems apparent, then, that the NCARP will be hard pressed to keep abreast of the continuing need for its services.

After a closer examination of the major agencies involved in North Carolina's mental effort, the various services of these agencies and their present needs should be more clearly defined in the mind of our readers. It should become apparent that, though the mental health agencies of our State government *are* working toward the same goal—emotional health for our citizens—each agency is functioning in a different and equally important area.

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
415 Halifax St.
RALEIGH, N. C.
Phone: 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: 3-8343
Monday through Friday

Mental Hygiene Clinic
210 N. Greene St.
GREENSBORO, N. C.
Phone: 3-9426
Also at HIGH POINT
Phone: 8929
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
Chapel Hill, N. C.
Phone 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: 3-5441 & 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: 3-2471, Ext. 29
Monday through Friday

Graylyn Hospital
WINSTON-SALEM, N C.
Phone: 3-7391
FRIDAY ONLY This is purely a Clinic for alcoholics and their families. Out - patient mental hygiene clinic is located at Baptist Hospital, Winston-Salem.

Toward helping patients to re-establish satisfactory social relations all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

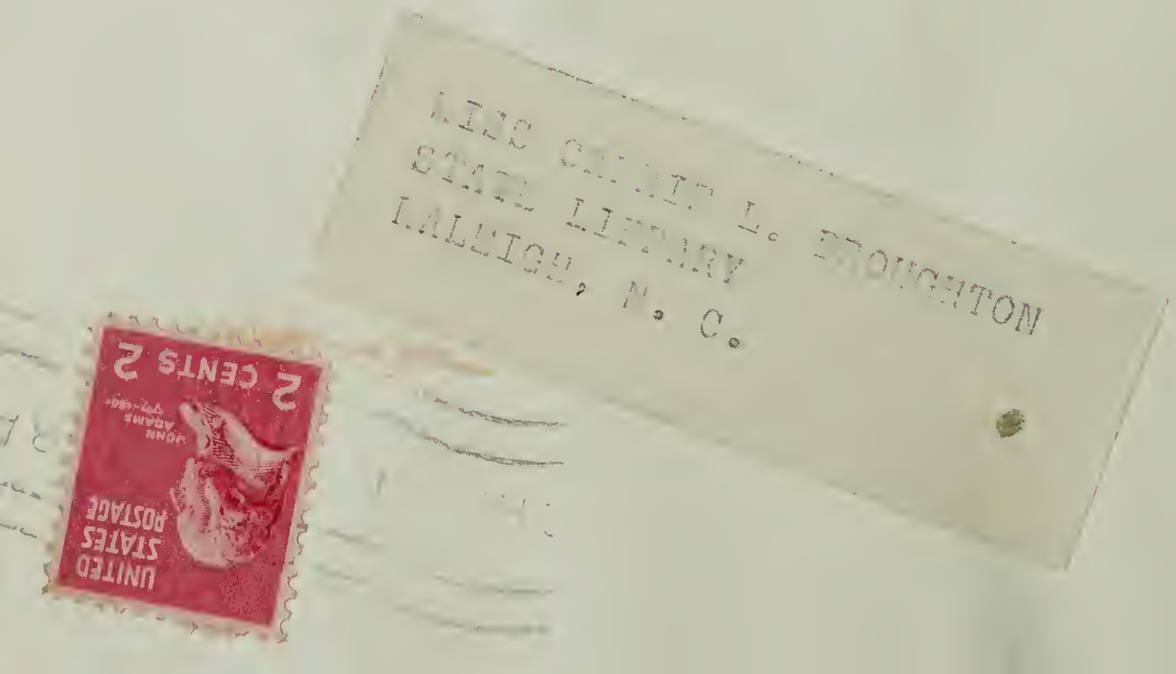
Library Kits—kits containing books and pamphlets on alcoholism. Available to libraries from N. C. Library Commission, State Library, Raleigh.

Book Loan Service—kit of reference works on alcohol and alcoholism, for high schools. Order from Education Director, 15 W. Jones St., Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
15 W. Jones St.
Raleigh, N. C.



Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

MARCH, 1955

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

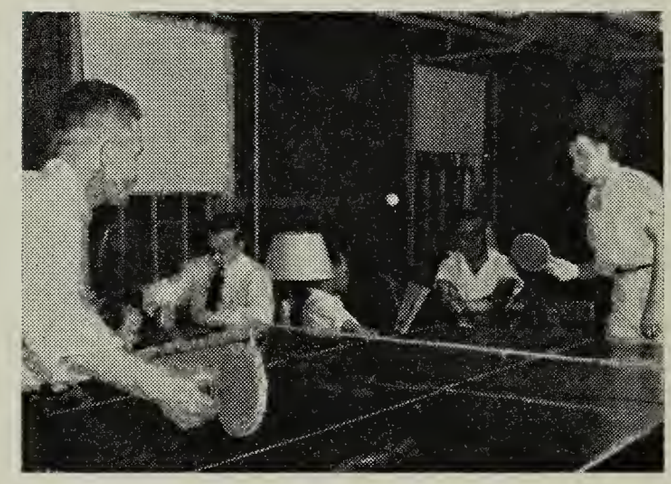
Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, a social worker, a recreation director, and occupational therapist, and ten attendants.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.
2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.



3. A fee of $75, in cash or certified check, must be paid upon admission.
4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illnesses. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
8 A.M. to 11 A.M. Saturday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

S. K. PROCTOR
Executive Director

NORBERT L. KELLY, Ph.D.
Educational Director

LORANT FORIZS, M.D.
Clinical Director

INVENTORY

VOLUME IV — NUMBER 6

MARCH, 1955

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices, 15 West Jones St., Raleigh, North Carolina.

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Circulation This Issue: 17,000

This journal is printed as a public information service. Persons desiring a place on the free mailing list must send in a written request. This journal will not be sent to persons other than those requesting it.

Write: INVENTORY, 15 W. Jones Street, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
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Valuable Teaching Material

Will you please add my name to your INVENTORY mailing list? I think it is an excellent publication and it will be valuable material for me to use in teaching. Thank you for this consideration.

Barbara Bernard
Associate Professor
Psychiatric Nursing
University of North Carolina
Chapel Hill, N. C.

Happy With Butner Education

I am extremely happy with the results of my own desires to remain completely sober, supplemented with the education I received at Butner . . . If one goes to Butner with a desire for aid, rest assured he can leave there with the best foundation obtainable to lead a life of total abstinence.

Name Withheld

Inventory Useful, Physician Says

I think INVENTORY is an excellent source of much useful and informative material. Only wish it could do everything we would like for it to do. Thank you for having me on your mailing list.

J. H. Cutchin, Jr., M.D.
Sherrills Ford, N. C.

Teachers Should Study Problem

I hope more and more teachers will avail themselves of the opportunity to study this problem (alcoholism), because not until teachers understand it thoroughly can they succeed in "getting it across" to their students.

Mrs. Margaret E. Copeland
Department of Science
East Durham Junior High School
Durham, N. C.

Minister Sends Congratulations

Your publication, INVENTORY, is both valuable and fascinating. My congratulations to all of you for the fine work you are doing at Butner and also along the lines of education. Our state has good reason to be proud of you.

Rev. H. Reid Newland
Cleveland, N. C.

AA's Discuss Inventory Articles

I have been getting INVENTORY through our local AA group in the past, but since we have so many discussions on articles therein, everyone seems to want the *one* copy we get. Please add my name to your mailing list.

R. H.
Goldsboro, N. C.

Teacher Requests ARP Literature

Last year you kindly sent to me a quantity of material on alcoholism for distribution and use in my class in Mental Hygiene. We are conducting the same course this year and again we would appreciate receiving any material on alcoholism that you might care to send us. Thank you for your help.

Roy R. Ullman
Professor of Psychology
Lenoir Rhyne College
Hickory, N. C.

Program Pointers

By S. K. Proctor
EXECUTIVE DIRECTOR

IN view of the interest shown in the past, it is not too early to outline our schedule of summer study courses on alcohol and alcoholism. Though not entirely complete at this time, our plans for broadening the scope of the NCARP's summer study program for professional people are beginning to take shape. We will continue and expand our summer courses on alcohol facts designed exclusively for teachers, and will again offer a limited number of scholarships to the Yale School of Alcohol Studies.

Already, we have received a number of preliminary inquiries from interested persons regarding scholarships to the Yale School, to be held during the period June 27 through July 22. The actual number of scholarships which we will have available will not be known until we are notified of our appropriation by the General Assembly now in session.

Problem Drinkers Discouraged

We again wish to discourage Yale scholarship applications from those who may be seeking help for their own drinking problem, or help for a family member who has a drinking problem. The purpose of the Yale School is to disseminate a wide variety of information on alcohol, alcoholism, and related problems. Its function is not that of a clinic providing treatment, or a counseling agency providing advice for the treatment of family members. Since our scholarships to Yale are limited, we are anxious that they go to professional persons whose work brings them into contact with alcoholics and their families, and whose influence may have the widest possible scope in their communities. Applications from social workers, welfare administrators, health educators, ministers, psychologists, law enforcement officers, school administrators and the like will be given top priority in our considerations.

Those who wish to apply for scholarships to the Yale Summer School of Alcohol Studies should address their inquiries to this Program, and get them into the mail immediately. The scholarship committee will meet sometime in the near future to select the scholarship recipients.

Yale Scholarships Limited

Every year since we have been offering this scholarship aid, we have had an increasing number of applications. There simply aren't enough scholarships to take care of every professional person who would like to attend Yale. We are particularly glad, therefore, to be able to offer specialized instruction for classroom teachers right here in some of our own North Carolina colleges.

We are expanding our sponsorship of Summer Studies on Facts About Alcohol, designed especially to meet the needs of teachers. In addition to the repeat courses offered again at East Carolina College in Greenville, Appalachian State College in Boone, and A. & T. College in Greensboro, we are scheduled to conduct a similar course at North Carolina College

(Continued on page 29)

News From 'Round The World

A feature designed to help you keep posted on developments in the field of alcoholism.

FLORIDA. The Florida State Program on Alcoholism gets underway with a whopping appropriation of $801,050 for the fiscal year 1954-55. Funds are being used to establish an inpatient treatment center at Avon Park and five outpatient clinics and to provide personnel and services for all phases of rehabilitation, treatment, education, and prevention. A very worthy program indeed under the expert guidance of Ernest A. Shepherd.

CONNECTICUT. Yale's Summer School of Alcohol Studies will convene for its 13th session this year on June 27 and will end on July 22. Dr. Selden Bacon, Director of the Summer School, emphasizes that the School is definitely not the place for anyone with a drinking problem. Those applicants who have had such a problem will be asked to give evidence of having been completely "dry" for 20 months prior to application. Simple criteria include: Emotional stability, a position making probable some effective use of this educational experience, educational achievement equivalent to college graduation, age sufficiently youthful so that use of the experience will not be automatically of brief duration. For scholarships or information query N. C. Alcoholic Rehabilitation Program if you live in this State. Otherwise query your own State Program. If no State Program write Dr. Bacon at Summer School of Alcohol Studies, Yale University, 52 Hillhouse Avenue, New Haven, Connecticut.

NORTH CAROLINA. Biggest news in the State this month is the activation of inpatient treatment services for alcoholics at N. C. Memorial Hospital at Chapel Hill. Any alcoholic citizen of North Carolina, whether white or Negro, male or female, drunk or sober, who desires treatment for alcoholism may apply for admittance on the referral of his or her doctor. Treatment, which includes psychotherapy, will be for a minimum of 10 days unless hospital authorities agree to a shorter period. Prospective patient should be prepared to pay on admittance full charges for 10-day treatment. These charges are not one cent more than the regular per diem rate charged any other type of patient who enters the hospital. Full charges for 10-day treatment will run somewhere between $150 and $225. Alcoholics interested only in "sobering up" are encouraged not to apply. Outpatient treatment services for alcoholics and/or their families are also provided at N. C. Memorial. The N. C. Alcoholic Rehabilitation Program has a special interest in this setup. Full story on it in the next issue of INVENTORY.

LOUISIANA. The Legislature has authorized a greatly expanded State Program on Alcoholism. Funds totaling $255,000 per year have been appropriated for inpatient and outpatient treatment and for study, research, education and coordination.

MINNESOTA. This State has been struggling along with an annual appropriation for its alcoholism program of $7,500. Now the State's Advisory Board on Problems of Alcoholism has recommended to the State Legislature that it appropriate $210,000 to meet the State's alcoholism problem during the coming biennium. Its Willmar State Hospital processes more than 300 alcoholic patients each month.

KANSAS. The Kansas State Commission on Alcoholism and the State Board of Health are sponsoring the popular radio series on alcoholism entitled **The Lonesome Road.** Five radio stations there began broadcasting it last month. Reports from other states which have used the dramatized series indicate high public interest in the series of 8 broadcasts. Inquiries from States other than North Carolina regarding the use of this transcribed series should be addressed to The Communications Center, Columbia University, New York City.

UNITED STATES. National Mental Health Week will be observed May 1-7. The purpose is to make every citizen aware of his stake in mental health. How citizens can help to create better mental health conditions will be explained via radio, television, the press, and numerous sponsoring organizations. Something to think about: six to seven per cent of the total population is suffering from mental or other personality disorders. 90% can be treated without hospitalization. One in twelve children born this year will at some time require treatment in a mental hospital. You have a stake. Cooperate!

THE GOLD COAST. A "loner" writes that there are no A.A. groups in this country and no interest in or facilities for treatment. He has asked that we put him in touch with other A.A. members. How about it, you A.A. guys and girls? The address: Box 112, Prestea, Gold Coast, West Africa.

SOUTH AFRICA. Aroused finally out of a lethargic attitude toward alcoholism, interested citizens in Cape Town have organized The Cape Peninsula Society For Education On Alcoholism and established an Alcoholism Information Centre. In less than three months it has given 132 interviews, referred 15 to A.A., arranged treatment for 14 acute cases, handled more than 500 telephone calls, and made a number of public addresses. Spark plug for this fast start is an Irishman (we assume) by the name of Patrick J. O'Foley.

HOLLYWOOD. Claiming that Hollywood pedestrians are mean and inconsiderate, Phil Harris complains that every time he sticks out his hand to signal a left turn some so-and-so steals the olive out of his martini.

The Editor's Page

Inventory
MARCH

YOUR EXTRA TWENTY YEARS

ORDINARILY I don't like statistics, especially to argue with. But I ran across some the other day concerning your life and mine that seemed to call for more thought than argument.

In case you're interested, your life expectancy has been increased twenty years since the turn of the century, and it has been handed to you on a silver platter by science and medicine with little relative increase in cost of services.

There are even now approximately 13,600,000 persons 65 and older in this country, a number that is growing at the rate of 900 per day. Since 1940 the number of persons 75 and older has increased more than 50 per cent, and we now have over 4,000,000 citizens who have reached or passed their seventy-fifth birthdays. It has been predicted that life expectancy will continue to increase and that by 1975 we will have in the United States 21,000,000 persons 65 years and older—about 12 per cent of the total population!

A famous doctor said recently that medical science has made more progress in the last fifty years than was made in the previous 3,000 years. The above statistics seem to prove it, and we're glad of it. But mental health does not necessarily accompany physical health during the process of aging. A vast number of the people over 65 are beset with haunting loneliness, feelings of frustration, uselessness and rejection, a frantic hunger for emotional security, recognition and prestige. They develop all kinds of aches and pains that defy medical diagnosis to compensate for their anxieties and general feelings of unhappiness. Many become alcoholics in their desperate search for something that will help them to feel better emotionally. What a pity that many people over 65 are spending their "extra" years as emotional invalids, unaware or unconcerned that they can be helped to emotional health and a happy, useful life to the end.

This is not their fault, of course. Terms like mental illness, personality maladjustment, neurosis, and psychotherapy are, to them, still polite words for describing the ills and treatment of "crazy" people. They do not realize that a chronic state of feeling uncomfortable, of being unhappy, of forever being tense or anxious, is an illness—an emotional illness that can be treated suc-

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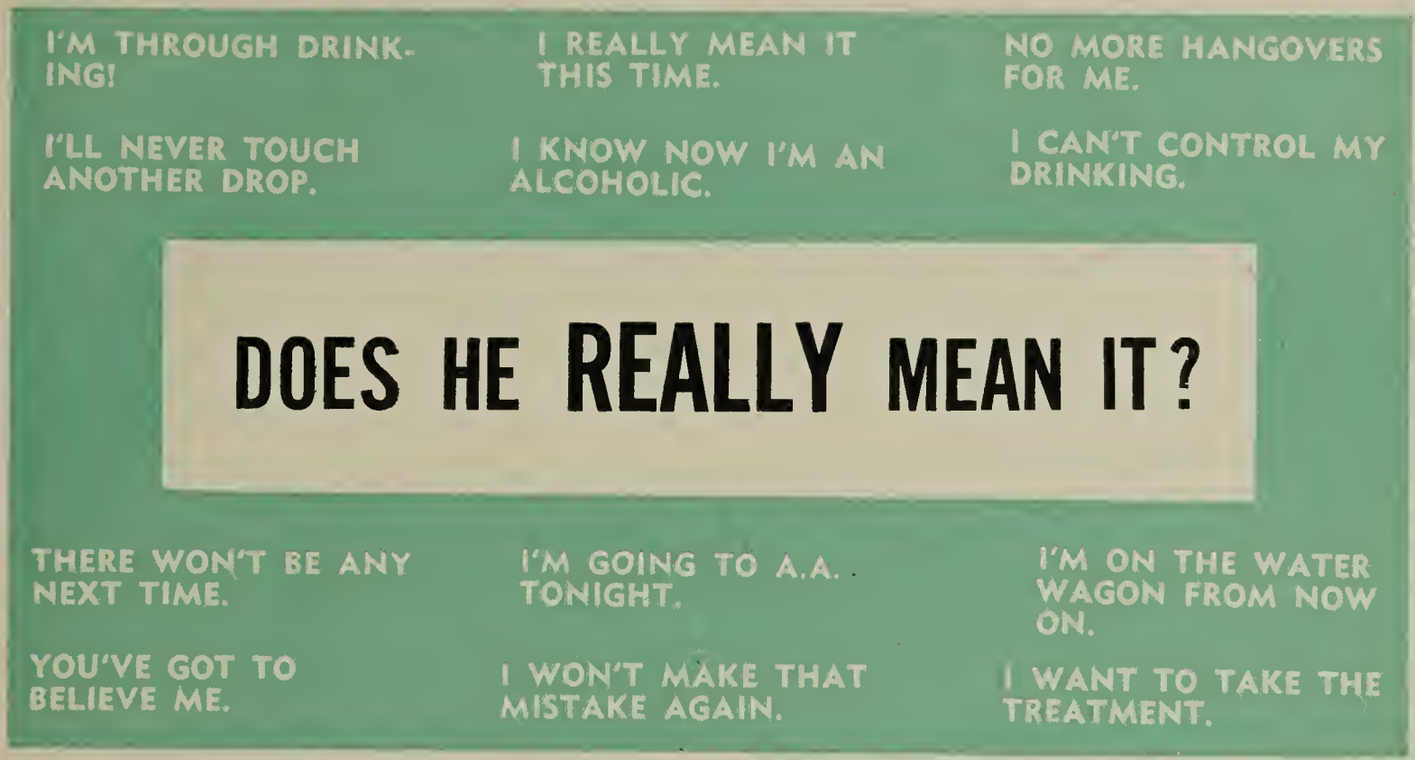
VOL. IV, No. 6 INVENTORY MARCH, 1955

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM



It's a good bet if Pride has been replaced by Humility. Here's how to tell the difference.

BY HORACE CHAMPION

OSCAR Wilde once said that experience is the name everyone gives to his mistakes. A business, a marriage, a significant undertaking of any kind fails miserably, and the person involved says, "What an experience that was! I won't make the same mistakes next time."

We all learn of our mistakes through experience, but unfortunately we do not always learn from our experience. Sometimes the new business or the new marriage fails, and suddenly the victim realizes that he has made the same mistakes all over again even though he knew which mistakes to avoid.

The alcoholic knows that he must not make the mistake of taking that first drink because experience has taught him that one drink is likely to lead to a drinking spree. But he takes the drink anyway, feeling that perhaps this time the mistake will not lead to the tragic experience. It does however, and his pride suffers a terrible blow. He knows that his wife and friends are thinking, "Won't you ever learn?" And again he assures one and all that he will never touch another drop, that he has learned from bitter experience. The same old story, loud, long, and seemingly sincere. But the wife knows, also from bitter experience, that she cannot rely on what the man says.

Yet we know that the hangover experience is very often the stimulus to actual recovery from alcoholism. Out of the deep remorse and painful reality of the hangover the alcoholic may have an emotional experience that starts him on the road to recovery. So we cannot discount completely the promises of the hangover victim—there is a possibility, admittedly a slim one, that this is the turning point in his drinking career.

But how can we tell? How can *he* tell? He knows as well as his wife

does that he has been unable to keep his promises in the past. He has had horrible hangovers before. He may have been a patient in several alcoholic treatment centers, and still he could not stop making the mistake of taking that first drink.

A mistake, like a drink, is a little thing usually. The average person pays little attention to it. But if he makes the same mistake over and over again, an unpleasant experience is likely to happen to him. The wife who makes the mistake of nagging her husband on numerous occasions may be divorced, and the husband who makes the mistake of demanding perfection in everything his wife does may be left to shift for himself. The single mistake is relatively unimportant. It is the repetition of the mistake that leads to the unpleasant experience.

It's A Mistake

One drink is unimportant, but for the alcoholic it is a mistake because it inevitably leads to the unpleasant experience of the hangover, of being thrown in jail, of being cruel to his family, etc.

But the alcoholic (or the wife or husband described) can be expected to continue making the same mistake until his *feelings* about the resulting experience are altered to a degree. Without some change in his emotional reaction to the experience he will not achieve recovery.

Pain Of The Hangover

To illustrate an experience in which the feelings appear to be involved but are actually unchanged consider the thoughts of this alcoholic coming out of a bender. The physical pain, the shattered nerves are bad enough. But the realization that his drinking is destroying his family's chance for happiness and security makes matters worse. He cannot deny this. It is too obvious. It is also obvious that "one drink is too many; and a barrel is not enough." These are the facts, and there is just one thing to do about it—stop drinking once and for all. Stop making that mistake. Never touch another drop. Get back to work. Make some money to pay the bills with. Buy the wife some decent clothes. Make her happy. Show her you can do it. But she won't believe you. She's heard the story too many times before. How can you show her you really mean it this time? Maybe you ought to take treatment for alcoholism like she says. Yes, that's it. That will make her happy. Maybe it'll work, too. She'll cry; she'll forgive you for this last bender. What a noble thing, swallowing your pride for the sake of someone you love, taking treatment for *alcoholism!*

It sounds good. It's reasonable. The emotional display accompanying his self-castigation and willingness to accept treatment makes it sound even better. But his line of thought indicates no real change in his attitudes and feelings about himself or his drinking. For the moment he is thinking rationally. What he thinks is true enough, but it is an intellectual evaluation of the situation, not an emotional acceptance of it.

Pride Fights Acceptance

In the hangover situation, a powerful emotional force, Pride, fights against the complete acceptance of any truth which might result in a further loss of self-respect and self-esteem. The alcoholic has precious little self-respect at the tail end of a bender and very little pride. Consequently, it is not surprising at this stage for him to admit that alcohol has him licked and to promise to do anything to overcome his alcoholism.

He sounds sincere, and he is sincere. He really means it. But Pride has great resiliency. Like the campfire that is doused with water and left smoldering, Pride can erupt in a fearful conflagration. The pain of the hangover and the shock of shattered nerves are soon gone. The alcoholic feels better mentally and physically, and it is at this stage that

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Is there a need for a middle stage of rehabilitation in the transition from dependence to independence?

HALFWAY HOUSE FOR ALCOHOLICS

MANY alcoholics adjust well to abstinence as long as they stay in a hospital or an institution. They seem to feel protected and safe and have no need to bolster their morale with alcohol. But when released and forced again to face the responsibilities of everyday life, they fail to make the grade. Alcohol is the means of escape from problems which they have been using all their lives, and it is not long before they fall into the established escape pattern.

The sudden change from the protection of an institution to independence in the outside world is believed to be particularly trying for the alcoholic. Many therapists have stressed the need for some sort of transitional care for these patients. A "Half-Way House" between the institution and complete freedom—a place where the alcoholic could stay for a time while he adjusts gradually to the responsibilities of free life—has often been suggested.

The Committee on Alcoholism of the City Welfare and Health Council, in discussing the Hart Island project for homeless men in New York, pointed out the need for a middle stage in the rehabilitation of alcoholics. To help these men avoid a return to drinking in this critical period, a Half-Way House is planned. There a number of men with common interests will share their meals, lodging and after-work recreation. They will pay for their board and help maintain and operate their middle-stage home. When a man has gained greater stability and is ready for the outside community, he will leave, making way for another coming from Hart Island.

Not A New Idea

The idea of the Half-Way House is by no means new. A. Sjohagen recently described the operation of such a home in the City of Malmo, Sweden. The staff consists of a superintendent and his wife, helped by a cook, kitchenmaid and room attendants. This house accommodates 20 guests, who have complete liberty except that they must be in by 10

(Continued on page 29)

WHY ALCOHOLICS ANONYMOUS

The co-founder of AA explains why anonymity is as vital to the life of AA as sobriety is to members.

AS never before the struggle for power, importance and wealth is tearing civilization apart. Man against man, family against family, group against group, nation against nation.

Nearly all those engaged in this fierce competition declare that their aim is peace and justice for themselves, their neighbors and their nation . . give us power and we shall have justice; give us fame and we shall set a great example; give us money and we shall be comfortable and happy. People throughout the world deeply believe that, and act accordingly. On this appalling dry bender, society seems to be staggering down a dead end road. The stop sign is clearly marked. It says "Disaster."

What has this got to do with anonymity, and Alcoholics Anonymous?

Dead-End Path

We of AA ought to know. Nearly everyone of us has traversed this identical dead end path. Powered by alcohol and self-justification, many of us have pursued the phantoms of self-importance and money right up to the disaster stop sign. Then came AA.

We faced about and found ourselves on a new high road where the direction signs said never a word about power, fame or wealth. The new signs read, "This way to sanity and serenity—the price is self-sacrifice."

Our new book, THE TWELVE STEPS AND TWELVE TRADITIONS, states that "Anonymity is the greatest protection our Society can ever have." It says also that "The spiritual substance of anonymity is sacrifice."

Let's turn to AA's twenty years of experience and see how we arrived at that belief, now expressed in our Traditions Eleven and Twelve.

At the beginning we sacrificed alcohol. We had to, or it would have killed us. But we couldn't get rid of alcohol unless we made other sacrifices. Big shot-ism and phony thinking had to go. We had to toss self-justification, self-pity, and anger right out the window. We had to quit the crazy contest for personal prestige and big bank balances. We had to take personal responsibility for our sorry state and quit blam-

IS ANONYMOUS

By Bill

ing others for it.

Were these sacrifices? Yes, they were. To gain enough humility and self-respect to stay alive at all we had to give up what had really been our dearest possession—our ambitions and our illegitimate pride.

But even this was not enough. Sacrifice had to go much further. Other people had to benefit too. So we took on some Twelfth Step work; we began to carry the AA message. We sacrificed time, energy and our own money to do this. We couldn't keep what we had unless we gave it away.

Did we demand that our new prospects give us anything? Were we asking them for power over their lives, for fame for our good work or for a cent of their money? No, we were not. We found that if we de-

manded any of these things our Twelfth Step work went flat. So these natural desires had to be sacrificed; otherwise, our prospects received little or no sobriety. Nor, indeed, did we.

Thus we learned that sacrifice had to bring a double benefit, or else little at all. We began to know about the kind of giving of ourselves that had no price tag on it.

Sacrifice For The Group

When the first AA group took form, we soon learned a lot more of this. We found that each of us had to make willing sacrifices for the group itself, sacrifices for the common welfare. The group, in turn, found that it had to give up many of its own rights for the protection and welfare of each member, and for AA as a whole. These sacrifices had to be made or AA couldn't continue to exist.

Out of these experiences and realizations, the Twelve Traditions of Alcoholics Anonymous began to take shape and substance.

Sacrifice Meant Survival

Gradually we saw that the unity, the effectiveness—yes, even the survival—of AA would always depend upon our continued willingness to sacrifice our personal ambitions and desires for the common safety and welfare. Just as sacrifice meant survival for the individual, so did sacrifice mean unity and survival for the group and for AA's entire Fellowship.

Viewed in this light, AA's Twelve Traditions are little else than a list of sacrifices which the experience of twenty years has taught us that we must make, individually and collectively, if AA itself is to stay alive and healthy.

In our Twelve Traditions we have set our faces against nearly every trend in the outside world.

We have denied ourselves personal government, professionalism and the right to say who our members shall be. We have abandoned do-goodism, reform, and paternalism. We refuse charitable money and prefer to pay our own way. We will cooperate with practically everybody, yet we decline to marry our Society to anyone. We abstain from public controversy and will not quarrel among ourselves about those things that so rip society asunder—religion, politics and reform. We have but one purpose: to carry the AA message to the sick alcoholic who wants it.

Learned Through Experience

We take these attitudes not at all because we claim special virtue or wisdom; we do these things because hard experience has told us that we must—if AA is to survive in the distraught world of today. We also give up rights and make sacrifices because we ought to—and, better yet, because we want to. AA is a power greater than any of us; it must go on living or else uncounted thousands of our kind will surely die. This we know.

Now where does anonymity fit into this picture? What is anonymity anyhow? Why do we think it is the greatest single protection that AA can ever have? Why is it our greatest symbol of personal sacrifice, the spiritual key to all our Traditions and to our whole way of life?

The following fragment of AA history will reveal, I deeply hope, the answer we all seek.

Years ago a noted ball player sobered up through AA. Because his

He: My wife explored my pockets again last night.
Him: What did she get?
He: The same as any other explorer—material for a lecture.
—From *The Nightcap*

comeback was so spectacular, he got a tremendous personal ovation in the press and Alcoholics Anonymous got much of the credit. His full name and picture, as a member of AA, was seen by millions of fans. It did us plenty of good; alcoholics flocked in. We loved this. I was specially excited because it gave me ideas.

Soon I was on the road, happily handing out personal interviews and pictures. To my delight, I found I could hit the front pages, just as he could. Besides, he couldn't hold his publicity pace, but I could hold mine. I only needed to keep traveling and talking. The local AA groups and newspapers did the rest. I was astonished when recently I looked at those old newspaper stories. For two or three years I guess I was AA's number one anonymity breaker.

Set The Example

So I can't really blame any AA who has grabbed the spotlight since. I set the main example myself, years ago.

At the time, this looked like the thing to do. Thus justified, I ate it up. What a bang it gave me when I read those two-column spreads about "Bill the Broker," full name and picture, the guy who was saving drunks by the thousands!

Then this fair sky began to be a little overcast. Murmurs were heard from AA skeptics who said, "This guy Bill is hogging the big time. Dr. Bob isn't getting his share." Or, again, "Suppose all this publicity goes to Bill's head and he gets drunk on us?"

This stung. How could they persecute me when I was doing so much good? I told my critics that this was America and didn't they know I had the right of free speech? And wasn't this country and every other run by big-name leaders? Anonymity was maybe okay for the average AA. But co-founders ought to be exceptions. The public certainly had a right to know who we were.

Real AA power-drivers (prestige-

(Continued on page 21)

IT'S BEEN SAID THAT . .

You have not converted a man because you have silenced him.
—J. Morley

Man always has two reasons for doing anything—a good reason and the real reason.—J. P. Morgan

It is always a silly thing to give advice, but to give good advice is absolutely fatal.—Wilde

An expert is a person who avoids the small errors as he sweeps on to the grand fallacy.—B. Stolberg

No man can lose what he never had.
—I. Walton

The greatest test of courage on the earth is to bear defeat without losing heart.—Ingersoll

It is much easier to be critical than to be correct.—Disraeli

Brevity is the soul of drinking, as of wit.—Lamb

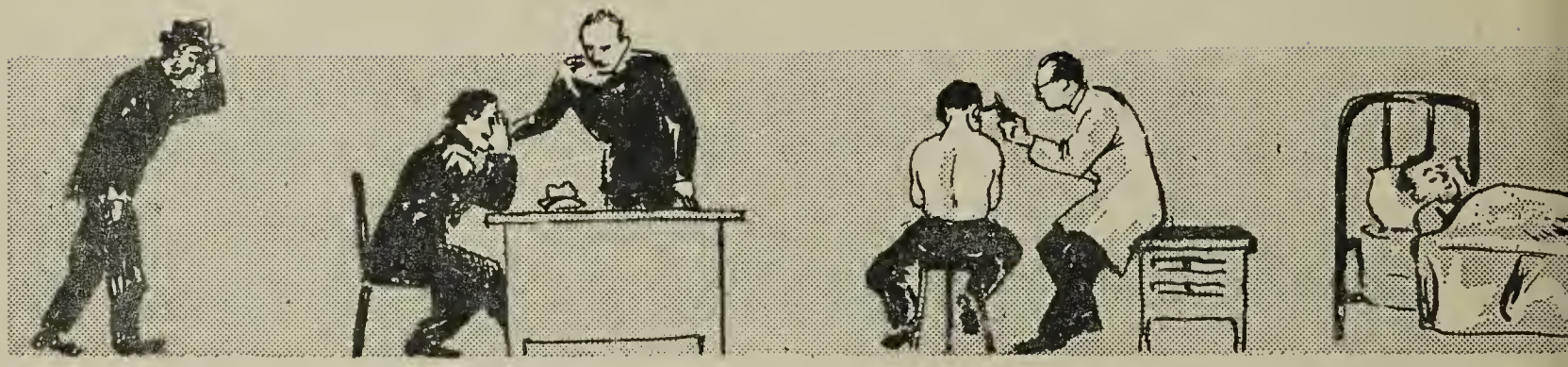
Woe unto them that rise up early in the morning, that they may follow strong drink.—Bible

He bids the ruddy cup go round, Till sense and sorrow both are drowned.
—Scott

A bumper of good liquor
Will end a contest quicker
Than justice, judge, or vicar.
—Sheridan

THE SALVATION ARMY'S

Clinic for



THE Salvation Army is one of our oldest and most respected social service organizations. But because the Army has been around for a long time doesn't mean that it isn't right up to date in its approach to social problems. The Army engages in a social welfare program aimed at caring for man's physical, and psychological needs as well as his spiritual ones.

Alcoholism, a sickness affecting all of these life areas, is getting an increasing share of attention from Salvation Army workers everywhere.

The Salvation Army's Social Service Center in Minneapolis, Minnesota—one of the nation's leading rehabilitation centers for homeless men—exemplifies this modern approach. Operating as an integral part of the Center's rehabilitation program is an Alcoholism Clinic, employing all the latest techniques for helping the alcoholic to recovery.

According to the Center's records, about 70 per cent of the men who turn to the Salvation Army for help have a drinking problem. Consequently a good deal of the rehabilitation work at the Minneapolis Social Service Center is directed toward the treatment and restoration of alcoholics.

Men Come Voluntarily

Clients come to the Service Center of their own free will. No inducements are held out and there is no "recruiting" by Army workers in the downtown slum areas of Minneapolis. News of the Center's services travels mostly by word of mouth. As its Personnel Director Dave Kellerher puts it, "The men have already made up their minds that they must do something to help themselves when they show up at our door—they've taken the *major* step."

This unique program gets results, too. Figures show that 80 per cent

The Salvation Army Clinic's scientific treatment method returns an average of 700 alcoholics each year to self-supporting trades.

BY GEORGE ADAMS

Alcoholics

of all clients of the Social Service Center are returned to active participation in their trades or in industry. This amounts to an average of 1,000 men a year, of whom about 700 are alcoholics. While the Clinic staff are modest about claiming such a high percentage of "permanent" recoveries from alcoholism, still these results are little short of amazing. It's no wonder the Minneapolis Chamber of Commerce hails the Army's Social Service Center for saving the city "some $100,000 in relief money each year."

The Center and its Alcoholism Clinic aim to provide the problem drinker with a wholesome environment; to help him change his attitudes toward his problems, through psychological and spiritual counseling; to provide him with productive work; and to see that he gets plenty of rest and a nutritious diet.

On hand to see that these aims are carried out are a Clinical Psychologist who is Director of the Alcoholism Clinic, three part-time physicians, a nurse, and a personnel director. All are under the direction of the Center's Manager, Senior Captain Cecil C. Briggs.

Let's see how the Center's Staff actually handles an alcoholic who applies for admission.

Admission Procedures

First, the applicant is interviewed and carefully screened by trained personnel. He may be among 50 or 60 men seeking entrance to the Social Service Center on any given day. Only a maximum of 20 men a day can be admitted. If the applicant is fortunate enough to be admitted, he is first provided with food and fresh clothing and then moves on to the next step—a thorough medical examination by a competent physician. An effort is made to determine how far along his alcoholism has prog-

(Continued on page 26)

PRIVATE KEEP OFF

BYE

TREATMENT

A.A.

PSYCHIATRY

PASTORAL COUNSELING

Champion

ALCOHOLICS ARE

OUT OF THIS WORLD

BY HORACE CHAMPION

The biggest problem any alcoholic has is getting back down to earth safely — and staying there!

THE magician who reaches into his top hat and pulls out a rabbit, a pigeon, a pitcher of water, and a beautiful corsage, is a rank amateur compared with the alcoholic who can find in a bottle the strength (?) to fight Jack Dempsey, the wisdom (?) to solve world problems, the courage (?) to tell his wife to shut up, the financial status (?) to buy drinks for everybody, the self-confidence (?) to tell the boss he's going to have a raise or else, the personality (?) to be the life of the party, and the ability (?) to make love like Clark Gable.

Like the magician's top hat the alcoholic's bottle has a false bottom and its purpose is to delude. The magician fools everybody but himself, and the alcoholic fools practically nobody except himself—he is his own fascinated audience.

When we learn how the magician performs the illusion, we are no longer thrilled by it. We wonder why we did not "catch on" sooner. That's the way it is with the alcoholic, too. When he is finally helped to understand the nature of *his* illusion and the secret of its performance he no longer feels like attending a repeat performance. He is ready to seek his thrills and satisfactions in the world of reality instead of in the realm of fantasy.

But it is not enough for him to seek reality; seeking is intellectual. He must learn to *accept* reality and all its vicissitudes, the pains and pleasures, the joys and sorrows, the comforts and discomforts that are part and parcel of life as it really is. In this sense, acceptance of reality is an emotional state that calms the troubled mind and enables it to face life's problems more objectively, without excessive fear and anxiety. To help the alcoholic patient accept reality is a goal of all successful forms of treatment.

Isn't Facing Reality

The intoxicated alcoholic who picks a fight with the local Golden Gloves champ, or buys drinks for everybody with his last five-dollar bill, or thinks he's God's gift to women, is suffering from an illusion; he certainly isn't facing reality.

But his intoxicated behavior does give us a clue as to the kind of per-

sonality he would like to be—and actually can be within reason—in real life.

He doesn't really want to beat up the boxing champion; but he *would* like to be more aggressive in his relationships with others. He doesn't really want to subsidize the drinking expenses of casual acquaintances at the local bar; but he *would* like to feel that he is noticed, accepted, appreciated. Buying drinks for others or giving a mere acquaintance his gold watch is his way of crying for love and affection. And as for making love like Gable, all he really wants is to feel that he is an adequate lover.

Goes To Extremes

The intoxicated alcoholic just can't help overacting the part he feels he must play in life's drama. And the sober alcoholic can't seem to help underacting his role. He goes from one extreme to the other. Sober, he might be mistaken for Casper Milquetoast, but give him a few drinks and he can be just as assertive as anybody. He won't hesitate to "tell off" the little woman or to buttonhole the boss for a raise with that "or else" speech he's been planning for months.

Intoxication is that magic state of mind that allows the alcoholic to be, temporarily, more like the kind of person he would like to be. But he overdoes it. He becomes too aggressive, too independent, too self-confident, too loving. This gets him into trouble because society and its more sober members simply will not allow us to deviate far from the norm without imposing sanctions. It's all right, society says, to stand up to the little woman and assert your rights; but if you slap her down you'll be charged with assault and battery. Society respects you for asking the boss to increase your salary commensurate with your worth to the firm, but you're liable to be fired for demanding a raise or else. The boss can impose sanctions, too.

The problem is to help the alcoholic "act out" his real feelings in day-to-day living on an emotional level acceptable to himself and to society.

Alcohol Must Go

He must learn to do this without the chemical crutch of alcohol because he has already demonstrated time after time that alcohol is—for him—a dangerous agent for the release of tensions. He cannot be sure that he can control the emotional energy freed by the alcohol any more than he can be sure he can control the number of drinks. Therefore, alcohol must go if he is to get an emotional grip on himself that will neither be too harsh on his own emotional needs nor too antagonistic to society's moral and social laws.

Help From Others

Complete abstinence is his first step toward facing the problem of acceptance of reality. Beyond that first step he must have the help of others if he is to recover from alcoholism.

The alcoholic who simply stops drinking through will power alone, whether for one week, one month, or two years, and considers the problem solved has a foggy view of his problem, to say the least. Similarly, the wife or mother who thinks that alco-

MATURITY

THE mature citizen is one who finds his individuality, expresses it, delights in it, in performing services which are contributing, necessary, and acceptable to society. This is the goal of any psychiatrist in his practice.

—By Kenneth E. Appel in the *American Journal of Psychiatry*

hol is *the* problem is due for a shock.

On the basis of sobriety alone he can be expected to continue to underact or overact because his biggest problem is an unrealistic approach to everyday living. He has this problem when he is sober as well as when he is drunk.

Take the alcoholic, for example, who has successfully gone "on the wagon" for a week or a month or whatever time has elapsed since he determined to give up drinking. He has done this through sheer will power—no help from anybody. No joining A.A. No talks with his doctor. No thought of going to a treatment center.

Dry Drunks

There is a tremendous surge of self-confidence, an all-powerful sense of self-control. He has conquered the problem single handed. He's very pleased with himself and he shows it. He acts as if he were walking on air, and figuratively speaking, he is "as high as a Georgia pine" although he's cold sober. AA's call this a "dry drunk" and it is not an uncommon occurrence among alcoholics who have succeeded in remaining sober for a longer period than usual.

Imbued with self-glorification and self-confidence, the alcoholic on a dry drunk acts very much like one on a wet drunk. Once again he is the all-powerful man of the house, the all-conquering lover, the alcoholic superman. But he cannot live up to this exaggerated view of himself because it is unrealistic. The dream collapses and once again he suffers from the despair, the self-blame, the deep remorse so characteristic of the alcoholic hangover—all without a drop to drink!

At this stage he needs just as much help in recovering from alcoholism as he did before he decided to stop drinking.

Another alcoholic who simply goes "on the wagon" might react quite differently after a period of sobriety, but his reaction is equally unrealistic. We will suppose that this one does not achieve the euphoric fantasy that the one described above experienced.

Instead, he becomes tense, nervous, jittery, and irritable. He's sober but he's mighty unhappy about it. He can't stand himself, much less other people. His morning egg is too soft and the toast is cold. His stenographer can't do anything right it seems, probably because she has a hangover. The children go out of their way to plague him, he's sure, when he's trying to get some rest, and if the neighbors don't stop their partying at 11 o'clock he's going to call the cops.

In the initial stages of sobriety a certain amount of nervousness and irritability can be expected, but when hate, suspicion and intolerance become usual emotional states in the period of sobriety we can be sure that the alcoholic is in danger of replacing one dream-world with one potentially as destructive.

The sober alcoholic will continue to be a bad actor in life's little drama

QUOTE OF THE MONTH
From the
KANNAPOLIS INDEPENDENT

The social drinker, before he realizes it, moves into the second stage—solitary drinking. He insists on bringing it home. Then follows the domestic argument. The more the argument, the more he is determined to continue. Soon he resents anyone speaking to him about it or warning him. The cost mounts. There is more argument, more drinking, verbal abuse, than actual physical abuse. More of the pay check is used to buy alcohol, which is expensive. Young people argue with their parents. Husbands and wives argue with one another and often come to actual blows. It is all perfectly nonsensical. etaoinshrudpywfmcvbgkqj½¼?z

Yes. Isn't it?

until he learns to play his part well enough to win both self-respect and the respect and appreciation of his society.

This is no easy task, but it is not impossible. It requires continuous striving on his part to accept the realities of life and it requires skillful direction on the part of those qualified to help him. Further, he must have enough confidence in his personally-chosen director to accept guidance without getting temperamental.

Helps Eliminate Faults

Behind every good actor is an even better director, one who appreciates and puts into play the finer points of the actor's ability and who helps to eliminate those faults that stand in the way of a good performance —faults which the actor himself is usually unaware of because the annoying little mannerisms have been repeated so often that they have become a part of his personality.

If the alcoholic is to play a satisfying role in life he too needs a good director. Once he has lost control over the use of alcohol he should never be so vain as to think that he can achieve the emotional stability necessary to react realistically to life's vicissitudes *without a good director*. It is impossible for him to see his problems objectively without help because they have become a part of him and will therefore continue to block a realistic approach to everyday living until they are brought to his awareness and faced.

Fortunately, the alcoholic has a choice of directors. In his search for recovery from alcoholism he may enlist the direction of Alcoholics Anonymous, whose membership is composed entirely of alcoholics who have recovered or are recovering. A.A. can show him that greater satisfactions exist in the sober world of reality than in the fickle world of alcoholic fantasy. A.A. can show him an approach to reality that has led many thousands of alcoholics out of the depths of alcoholic despair and started them on the road to sobriety and real happiness.

The alcoholic may prefer the direction offered by psychiatry, which is often called the art of understanding. Practically all alcoholics feel that they are misunderstood, unappreciated and looked down on. Psychiatry understands, accepts, frees the patient's mind of negative self-feeling, and through techniques designed to give him self-understanding inspires a philosophy of life based on reality.

Psychiatry is the core of treatment at the N. C. Alcoholic Rehabilitation Treatment Center. It is also used in therapy for alcoholics at all Mental Hygiene Clinics and at the N. C. Memorial Hospital at Chapel Hill.

Some alcoholics find the direction they need toward living realistically and soberly in the acceptance (not the mere intellectual acknowledgment) of God as a reality and something to live by. Through the help of well-informed pastoral counsellors many alcoholics have found a guide to confident living that they could not get elsewhere.

Often the psychiatric social worker and the social case worker are able to give the direction needed to start one on the road to reality.

More often it is the help of several agencies and qualified individuals rather than just one that directs the alcoholic finally to his goal of living soberly, happily, and realistically.

MEN always have and always will be struggling with problems of feelings and ideas, and as always their greatest aid and support will come from their fellows—in this day and age, from medically-trained "professional friends" as well as from those who are closest to them.

—Karl M. Bowman and Milton Rose in *Am. Journal of Psychiatry*

Why Alcoholics Anonymous Is Anonymous

(Continued from page 13)

hungry people, folks just like me) weren't long in catching on. They were going to be exceptions too. They said that anonymity before the general public was just for timid people; all the braver and bolder souls, like themselves should stand right up before the flash bulbs and be counted. This kind of courage would soon do away with the stigma on alcoholics. The public would right away see what fine citizens recovered drunks could make. So more and more members broke their anonymity, all for the good of AA. What if a drunk was photographed with the Governor? Both he and the Governor deserved the honor, didn't they? Thus we zoomed along, down the dead end road!

Alcohol Education

The next anonymity breaking development looked even rosier. A close AA friend of mine wanted to go in for alcohol education. A department of a great university interested in alcoholism wanted her to go out and tell the general public that alcoholics were sick people, and that plenty could be done about it. My friend was a crack public speaker and writer. Could she tell the general public that she was an AA member? Well, why not? By using the name Alcoholics Anonymous she'd get fine publicity for a good brand of alcohol education and for AA too. I thought it an excellent idea and therefore gave my blessing.

AA was already getting to be a famous and valuable name. Backed by our name and her own great ability, the results were immediate. In nothing flat her own full name and picture, plus excellent accounts of her educational project, and of AA, landed in nearly every large paper in North America. The public understanding of alcoholism increased, the stigma on drunks lessened, and AA got new members. Surely there could be nothing wrong with that.

But there was. For the sake of this short-term benefit, we were taking on a future liability of huge and menacing proportions.

Prohibition Magazine

Presently an AA member began to publish a crusading magazine devoted to the cause of Prohibition. He thought Alcoholics Anonymous ought to help make the world bone dry. He disclosed himself as an AA member and freely used the AA name to attack the evils of whiskey and those who made it and drank it. He pointed out that he too was an "educator," and that his brand of education was the "right kind." As for putting AA into public controversy, he thought that was exactly where we should be. So he busily used AA's name to do just that. Of course, he broke his anonymity to help his cherished cause along.

Another Proposal

This was followed by a proposal from a liquor trade association that an AA member take on a job of "education." People were to be told that too much alcohol was bad for anyone and that certain people—the alcoholics—shouldn't drink at all. What could be the matter with this?

The catch was that our AA friend had to break his anonymity; every piece of publicity and literature was to carry his full name as a member of Alcoholics Anonymous. This of course would be bound to create the

definite public impression that AA favored "education," liquor trade style.

Though these two developments never happened to get far, their implications were nevertheless terrific. They spelled it right out for us. By hiring out to another cause, and then declaring his AA membership to the whole public, it was in the power of an AA to marry Alcoholics Anonymous to practically any enterprise or controversy at all, good or bad. The more valuable the AA name became, the greater the temptation would be.

Advertising Scheme

Further proof of this was not long in showing up. Another member started to put us into the advertising business. He had been commissioned by a life insurance company to deliver a series of twelve "lectures" on Alcoholics Anonymous over a national radio hookup. This would of course advertise life insurance and Alcoholics Anonymous—and naturally our friend himself—all in one good-looking package.

At AA Headquarters, we read the proposed lectures. They were about 50 per cent AA and 50 per cent our friend's personal religious convictions. This could create a false public view of us. Religious prejudice against AA would be aroused. So we objected.

Our friend shot back a hot letter saying that he felt "inspired" to give these lectures, and that we had no business to interfere with his right of free speech. Even though he was going to get a fee for his work, he had nothing in mind except the welfare of AA. And if we didn't know what was good for us, that was too bad! We and AA's Board of Trustees could go plumb to the devil. The lectures were going on the air.

This was a poser. Just by breaking anonymity and so using the AA name for his own purposes, our friend could take over our public relations, get us into religious trouble, put us into the advertising business and, for all these good works, the insurance company would pay him a handsome fee.

Did this mean that any misguided member could thus endanger our Society any time or any place simply by breaking anonymity and telling himself how much good he was going to do for us? We envisioned every AA advertising man looking up a commercial sponsor, using the AA name to sell everything from pretzels to prune juice.

Project Abandoned

Something had to be done. We wrote our friend that AA had a right of free speech too. We wouldn't oppose him publicly, but we could and would guarantee that his sponsor would receive several thousand letters of objection from AA members if the program went on the radio. Our friend abandoned the project.

But our anonymity dike continued to leak. AA members began to take us into politics. They began to tell

RUM DE DUM DUM

TWO inebriated gentlemen, somewhat the worse for wear, sat at a table near the bar. They discoursed on national and international topics in a curiously slow and garbled manner. Finally, near the end of the bottle, one of them tipped back in his chair, lost his balance, and landed flat on his back on the floor. His buddy waited patiently for a few minutes, then looked across the table down at his prostrate companion and said in a rather worried voice, "You're coming back, aren't you?"

State Legislative committees—publicly, of course—just what AA wanted in the way of rehabilitation, money and enlightened legislation.

Thus, by full name and often by pictures some of us became lobbyists. Other members sat on benches with police court judges, advising which drunks in the line-up should go to AA and which to jail.

Money Complications

Then came money complications involving broken anonymity. By this time, most members felt we ought to stop soliciting funds publicly for AA purposes. But the educational enterprise of my university-sponsored friend had meanwhile mushroomed. She had a perfectly proper and legitimate need for money and plenty of it. Therefore, she asked the public for it, putting on drives to this end. Since she was an AA member and continued to say so, many contributors were confused. They thought AA was in the educational field or else they thought AA itself was raising money when indeed it was not and didn't want to.

So AA's name was used to solicit funds at the very moment we were trying to tell people that AA wanted no outside money.

Seeing what happened, my friend, wonderful member that she is, tried to resume her anonymity. Because she had been so thoroughly publicized, this has been a hard job. It has taken her years. But she has made the sacrifice, and I here want to record my deep thanks on behalf of us all.

This precedent set in motion all sorts of public solicitations by AAs for money—money for drying-out farms, Twelfth Step enterprises, AA boarding houses, clubs, and the like—powered largely by anonymity breaking.

We were next startled to learn that we had been drawn into partisan politics, this time for the benefit of a single individual. Running for public office, a member splashed his political advertising with the fact that he was an AA and, by inference, sober as a judge! AA being popular in his State, he thought it would help him win on election day.

Used In Lawsuit

Probably the best story in this class tells how the AA name was used to back up a libel lawsuit. A member, whose name and professional attainments are known on three continents, got hold of a letter which she thought damaged her professional reputation. She felt something should be done about this and so did her lawyer, also an AA. They assumed that both the public and AA would be rightfully angry if the facts were known. Forthwith, several newspapers headlined how Alcoholics Anonymous was rooting for one of its lady members—named in full, of course—to win her suit for libel. Shortly after this, a noted radio com-

mentator told a listening audience, estimated at twelve million people, the same thing. This again proved that the AA name could be used for purely personal purposes . . . this time on a nationwide scale.

The old files at AA Headquarters reveal many scores of such experiences with broken anonymity. Most of them point up the same lessons.

They tell us that we alcoholics are the biggest rationalizers in the world; that fortified with the excuse we are doing great things for AA we can, through broken anonymity, resume our old and disastrous pursuit of personal power and prestige, public honors, and money—the same implacable urges that when frustrated once caused us to drink; the same forces that are today ripping the globe apart at its seams. Moreover, they make clear that enough spectacular anonymity breakers could someday carry our whole society down into that ruinous dead end with them.

So we are certain that if such forces ever rule our Fellowship, we will perish too, just as other societies have perished throughout human history. Let us not suppose for a moment that we recovered alcoholics are so much better or stronger than other folks; or that because in twenty years nothing has ever happened to AA, that nothing ever can.

Hard Won Lessons

Our really great hope lies in the fact that our total experience, as alcoholics and as AA members, has at last taught us the immense power of these forces for self-destruction. These hard won lessons have made us entirely willing to undertake every personal sacrifice necessary for the preservation of our treasured Fellowship.

This is why we see anonymity at the general public level as our chief

TIPS ON MENTAL HEALTH

WE might say that one of the most regrettable human feelings is our inability to keep free from anxiety whenever we are confronted with a new idea, and that the most common defense against such anxiety is hostility, intolerance, incapacity to see the other person's point of view. The anxiety about anything new leads us inevitably to a sort of retreat or regression to older and therefore "safer" habits of thought, and the result is an inevitable loss of energy and creative vision.

—Gregory Zilborg, M.D., in *Am. Journal of Psychiatry*

CHIDREN grow into healthy or unhealthy minded adults largely on the basis of their earlier experiences in the home. No child is born nervous or emotionally unstable, doomed to unhappiness, but any child may become so in an unfavorable home environment. Parents, therefore, if not for their own sake, certainly for the sake of their children, should know the common dangers to mental health and how to avoid them. —Laurence Spurgeon McLeod in *Mental Health in the Home*

IT is no disgrace today to admit that one has emotional problems. More and more people consult psychiatrists—who are simply physicians with special training and experience—when they feel they cannot go it alone. Often they find, much to their surprise, they are a lot stronger than they thought they were, and able to cope with life's struggles with just a little help.

—Lucy Freeman in *Today's Health*

protection against ourselves, the guardian of all our Traditions and the greatest symbol of self-sacrifice that we know.

Of course no AA need be anonymous to family, friends, or neighbors. Disclosure there is usually right and good. Nor is there any special danger when we speak at group or semi-public AA meetings, provided press reports reveal first names only.

But before the general public—press, radio, films, television and the like—the revelation of full names and pictures is the point of peril. This is the main escape hatch for the fearful destructive forces that still lie latent in us all. Here the lid can and must stay down.

Anonymity Vital

We now fully realize that 100 per cent personal anonymity before the public is just as vital to the life of AA as 100 per cent sobriety is to the life of each and every member. This is not the counsel of fear, it is the prudent voice of long experience. I am sure that we are going to listen; that we shall make every needed sacrifice. Indeed we have been listening. Today only a handful of anonymity breakers remain.

I say all this with what earnestness I can; I say this because I know what the temptation of fame and money really is. I can say this because I was once a breaker of anonymity myself. I thank God that years ago the voice of experience and the urging of wise friends took me out of that perilous path into which I might have led our entire Society. Thus I learned that the temporary or seeming good can often be the deadly enemy of the permanent best. When it comes to survival for AA, nothing short of our very best will be good enough.

Hurts Public Relations

We want to maintain 100 per cent anonymity for still another potent reason, one often overlooked. Instead of securing us more publicity, repeated self-serving anonymity breaks could severely damage the wonderful relation we now enjoy with press and public alike. We could wind up with a poor press and little public confidence at all.

For many years, news channels all over the world have showered AA with enthusiastic publicity, a neverending stream of it, far out of proportion to the news values involved. Editors tell us why this is. They give us extra space and time because their confidence in AA is complete. The very foundation of that high confidence is, they say, our continual insistence on personal anonymity at the press level.

Refreshing Novelty

Never before had news outlets and public relations experts heard of a society that absolutely refused personally to advertise its leaders or members. To them, this strange and refreshing novelty has always been proof positive that AA is on the square; that nobody has an angle.

This, they tell us, is the prime reason for their great good will. This is why, in season and out, they continue to carry the AA message of recovery to the whole world.

If, through enough anonymity lapses we finally caused the press, the public and our alcoholic prospects themselves to wonder about our motives, we'd surely lose this priceless asset; and, along with it, countless prospective members. Alcoholics Anonymous would not then be getting more good publicity; it would be

getting less, and worse. Therefore the handwriting on the wall is clear. Because most of us can already see it, and because the rest of us soon will, I'm fully confident that no such dark day will ever fall upon our Society.

For a long time now, both Dr. Bob and I have done everything possible to maintain the Tradition of Anonymity. Just before he died, some of Dr. Bob's friends suggested that there should be a suitable monument or mausoleum erected in honor of him and his wife, Anne, something befitting a Founder. Dr. Bob declined, with thanks. Telling me about this a little later, he grinned and said, "For Heaven's sake, Bill, why don't you and I get buried like other folks?"

Anonymity To The End

Last summer I visited the Akron cemetery where Bob and Anne lie. Their simple stone says never a word about Alcoholics Anonymous. This made me so glad I cried. Did this wonderful couple carry personal anonymity too far when they so firmly refused to use the word "Alcoholics Anonymous," even on their own burial stone?

For one, I don't think so. I think that this great and final example of self-effacement will prove of more permanent worth to AA than could any spectacular public notoriety or fine mausoleum.

We don't have to go to Akron, Ohio, to see Dr. Bob's memorial. Dr. Bob's real monument is visible throughout the length and breadth of AA. Let us look again at its true inscription . . . one word only, which we AAs have written. That word is Sacrifice.

The Salvation Army's Clinic For Alcoholics

(Continued from page 15)

ressed, and whether he is in need of immediate treatment for the acute effects of drinking.

Cases that arrive at the Center and are unable to be interviewed due to acute intoxication are sent to a "drying out" room and put to bed. They are visited there by a physician who decides whether or not medication is necessary or if there are any serious complications which might warrant hospital care.

After his physical condition has been attended to, the client moves to the next phase of the Center's rehabilitation plan—thorough psychological testing by the staff psychologist. This sort of testing helps to reveal the man's strengths and weaknesses, his attitudes and feelings. The tests also help to indicate the kind and extent of treatment which will be most beneficial to the alcoholic client.

Therapy Interviews

After testing, our client is scheduled for regular interviews with a professional psychotherapist, and treatment for the emotional aspects of his illness really begins. In his interviews with the therapist, the client goes through a process of emotional re-education, in which, ideally, he will gain awareness of his emotional problems, some understanding of how to cope with them, and will learn how better to live with him-

A PREACHER walked into the tavern in the course of his welfare work and ordered a glass of milk. By mistake he was served an eggnog. After drinking it to the last drop he raised his eyes upward and was heard to say, "Lord, what a cow!"—From **Chit-Chat**

self and his society.

While continuing his therapy over an indefinite period of time, the alcoholic client of the Salvation Army Center is next handed a work assignment, based on aptitude tests given earlier. There are a variety of jobs available throughout the many operations of the Center. Perhaps he will be assigned as a truck driver's helper, an office worker, to the woodworking shop, or to one of the several shops salvaging various waste materials for re-sale.

The client's pay for working is only about $3 a week—enough to take care of his personal needs, such as cigarettes, coffee, and soft drinks at the canteen. In addition, of course, he gets his board and lodging, and full use of the Center's recreational facilities.

If the client proves to have aptitude for a particular job he may be promoted to the status of regular employee and be paid the standard wage scale for the job he is doing. The important thing is that the alcoholic who was formerly a drain on his society is again engaged in productive work, which will keep him off relief rolls and send him back to an industry or trade as a self-supporting, self-respecting worker.

During the time that the alcoholic client is living and working at the Rehabilitation Center, he is free to take advantage of a number of resources to help him with the job of reintegrating his life. He may wish to join Alcoholics Anonymous. A regularly organized AA group is operating with the Center as a part of the rehabilitation program.

Spiritual Counseling

Spiritual counseling is available at any time on a voluntary basis. Two Salvation Army officers who are ordained ministers are on hand to provide this type of help. Regular religious services are held, and a male choir and Bible class hold weekly meetings. These are enthusiastically supported by the client population of the Center. Captain Briggs and his staff believe an individual's return to a healthy religious life goes right along with his physical and mental return to normalcy. Every opportunity to achieve this well-rounded result is offered to alcoholics under the Center's program.

Occupational Therapy

The alcoholic client may desire to participate in the occupational therapy program. A recent innovation, this phase of the work is under the guidance of a graduate student from the University of Minnesota. In the O. T. shop, the problem drinker may become interested in some hobby activity which, in addition to providing enjoyment, will help him to maintain sobriety.

Residents of the Center are allowed complete freedom of action outside

of work hours. A minimum of regulations are in effect to maintain proper control of the institution. Recreational activity—television, radio, piano, card-room, pool room, horseshoes—are all available.

A number of auxiliary services are maintained for the benefit of clients. More prominent among these is a low-cost clothing store where new clothing can be purchased at cost, and a snack bar where between-meal snacks are served at low cost. Aid is given the client in connection with pensions, government compensation claims, unemployment insurance, legal and family problems.

The alcoholic's stay at the Social Service Center is indefinite. About one-third of the Center's case load leaves within the month. The remainder stays between an average of six months and two years. No matter how long a man remains, though, the aim of the Salvation Army Center is to return him to society rehabilitated physically, mentally, and spiritually, and capable of self-support. Admittedly, that is a big order. But through the application of well-rounded, modern techniques the Salvation Army's Minneapolis Center is accomplishing the job in the majority of cases. As Captain Briggs says, speaking for the Center which he manages, "We believe that a man relieved of the disease of alcoholism will return to industry as a valuable workman, and we have proved it in thousands of cases."

LETTER FROM AN A.A.

To me AA is like a reprieve from the death chamber or a life behind bars. You are just about ready to give up and when you do, lo and behold you just really start to live. It is just like getting a parole from a life sentence. There are certain regulations that you must follow, or back to prison you must go. There is always a parole officer watching you to see that you carry out these regulations, but in AA there is only your own conscience to worry about. And if we don't do the suggested steps in order to get and maintain sobriety, then like the parolee who goes back to prison, we go back to our own kind of prison—the squirrel cage.

But when the alcoholic comes to AA and tries to live up to the principles that he or she has learned from the Twelve Steps, it isn't very long before they are living good, decent lives, not because of their conscience or that they are afraid of the old squirrel cage, but only because they have found Faith. Through Faith they have come to know God and through knowing God they have come to learn the kind of life that God would want them to live, and they try to live this life a little better each day. This is not done in fear but in trying to reach perfection, which is a long ways off for us, but we keep on reaching, and someday, who knows where we will end?

For it is not what we do that counts, but how hard we try. I will die, sure, but I will go out knowing that I honestly tried to help my brother alcoholic, not when he asked but when I thought he needed help. I will go out knowing that I had at last brought a little love and happiness to my wife and family. And last but not least, I will go out being a better man through having been in AA.

Leon D., Sudbury, Canada
—Reprinted from **Chit-Chat**

Halfway House For Alcoholics

(Continued from page 9)

o'clock in the evening. During the day they work at their usual occupations. They are thus able to pay for their room and board and to contribute toward the support of their families.

According to Sjohagen the success of a Half-Way House depends on the persons who operate it. They must be able to maintain order and discipline, and at the same time make the atmosphere pleasant and homelike so that return to the house after work will seem desirable to the guests. They thus become somewhat like substitute parents for the patients. Experience has shown that an attitude of good will is appreciated by the patients, who thus learn to trust the supervisors and confide in them. The meals provided are nourishing but not luxurious; a great deal of coffee is used, a fact much appreciated by the abstaining guests.

Effect On Family Life

While the Half-Way House proposed for New York is aimed to provide a home for men without a family, the Swedish hospice aims at serving also the needs of people who have families but are not ready to resume family life. It enables the recovering alcoholic to start life in freedom and in a homelike atmosphere, but one not charged with the emotional entanglements of his own home. It is a fact that, for some alcoholics, immediate return to the family may loom as a threat and may bring about a crisis which will soon lead again to drinking. Staying for some time at the Half-Way House, and seeing his family in a limited way, often gives the patient time to iron out the difficulties of the past, to gain confidence in himself, and gradually to accept his responsibilities. For those who do not have a family, the orderly life of the Half-Way House often starts a pattern of living which, in time, they learn to follow on their own.

Program Pointers

(Continued from page 3)

in Durham. Negotiations for an alcohol study course to be held at Fayetteville State Teachers College are in progress and we hope to complete them in the near future.

As you know, North Carolina, as well as all the other states, has a law requiring the teaching of alcohol facts in the classroom. Our experience has been that teachers are intensely interested in meeting their responsibilities in this area. Too often in the past a combination of factors, including the scarcity of good teaching materials, the opposition of school boards or community groups, have made it difficult for teachers to do an effective job of teaching alcohol facts.

It is the aim of NCARP through these summer courses to provide teachers with up-to-date, scientific information about alcohol and the illness of alcoholism, and to show their relationship to mental health. Ideally, attendance at one of these summer schools will not only help teachers to do a better job of teaching alcohol facts, but to be more effective in preventing alcoholism through early recognition of personality maladjustment in their young students.

Well Received

Our summer schools for teachers have been well received in the past and we anticipate a continuation of their popularity. The course at East Carolina has for the past two years enjoyed the largest attendance of any course on the campus. Comments from teachers in attendance here and at the other colleges were highly complimentary as to content

and method of presentation. We hope that many of our public school teachers are already making plans to attend one of these summer schools on alcohol studies this year.

As we go to press, arrangements have been completed for a community institute on alcoholism to be held in Morehead City, N. C., February 23-24. Mr. Raymond McCarthy, internationally known alcohol educator, will speak to several community groups during the two-day session. Sharing the speaking duties with Mr. McCarthy will be Dr. Joseph Garrison, Presbyterian minister from Greensboro, Dr. John Ewing, psychiatrist at the UNC Medical School, and Miss Roberta Lytle of our Raleigh staff.

Jaycee-Sponsored

The Morehead City institute is being sponsored by the Junior Chamber of Commerce of that city. As you may know, the State Jaycee organization adopted alcoholism education as a project for the year, and are encouraging Jaycee locals to promote educational programs in their local communities. A number of Jaycee groups have called on the NCARP for assistance in drawing up their plans of action. We are happy to have had a part in arrangements for the Morehead City Institute, and will welcome the opportunity to aid other Jaycee groups over the State in similar efforts.

N. C. Memorial Facilities

For a long time now, we of the NCARP have followed with interest the growth and development of N. C. Memorial Hospital at Chapel Hill. We are proud of the facility there, and believe that it will contribute in ever increasing measure to the welfare of the people of our State. It is particularly gratifying to be able to announce that the illness of alcoholism will be treated at N. C. Memorial. Alcoholics are now being admitted to the hospital in Chapel Hill in any phase of their illness, including the acute or "sobering up" phase.

This is a long looked-for development, and certainly one which will fill a great need. Provision of treatment facilities for alcoholics at N. C. Memorial is the culmination of a long period of consultation and planning. Several years ago, your Director took part in a series of discussions with officials of N. C. Memorial, looking toward an alcoholism service for the hospital. The NCARP was privileged to be able to channel some of its available funds to help make the physical facilities for the treatment of alcoholics possible.

Not A Drying Out Place

We are, understandably, very pleased and encouraged that the doors of N. C. Memorial Hospital are open to the sick alcoholic, as well as to other ill people. The staff of the hospital wishes me to emphasize that, though they are accepting intoxicated patients, they do not want their service to become merely a "drying out" place. For that reason, patients will be expected to remain in the hospital for at least a 10-day period, during which time psychotherapy will be instituted, aimed at getting at the deeper causes of the patient's drinking. Each alcoholic patient will be encouraged to follow up his hospital treatment with regular appointments in the out-patient service.

Rates for the 10-day treatment period for alcoholics will be the same as the prevailing per diem rate for all other patients in the hospital. No rate discrimination will be made in the case of alcoholics. The hospital will require that payment for the 10-day treatment period be made in advance.

DAFFY-NITIONS

Neurotic: One who believes the world owes him a loving.
Alcohol: A liquid for preserving almost anything but secrets.

—From **Night Cap**

Does He Really Mean It?

(Continued from page 8)

the alcoholic can determine for himself if he has *learned* from the experience of the last bender, if he has developed the right attitude for continued sobriety with help.

He cannot do this unless he understands the true meaning of two important words, Pride and Humility. He should look them up in a good dictionary even if he's quite sure what they mean, to refresh his memory if nothing else. Humility is the very antithesis of Pride and must be acquired before the alcoholic (or anybody else for all that matters) can accept the good and bad in himself without excessive anxiety or other emotional pain.

Humility Prevails

When the alcoholic *"learns"* from the experience of the bender and resulting hangover, Humility prevails, not just during the sobering up period but also after physical health has been restored. The alcoholic continues to feel that he is an alcoholic and he wants to accept treatment *for his own sake* as well as for the sake of his family. He can go to a treatment center or to A.A. without shame. It is as if all the fight had been taken out of him by this last bender, but his is not the kind of resignation that leaves him sad and hopeless. Quite the contrary, he has a positive state of mind. He looks to the future with hope and quiet confidence, but he doesn't brag about it. This description of the feelings and attitudes resulting from the acquisition of Humility is admittedly exaggerated, but it may give the sober alcoholic some basis for determining whether he has acquired some degree of this cherished state of mind.

Pride Is Clever

By contrast consider the characteristics of Pride and the extremely clever ways in which it operates to prevent Humility from gaining the upper hand. An imagined "conversation" between an alcoholic whose hangover experience taught him nothing and his Feeling of Pride might help one to understand when his motivation for recovery from alcoholism is poor. He has shed all the tears and made all the usual promises, and now that he has recovered from the physical effects of the bender he is faced with the challenge of doing all the things he said he would do, including taking treatment for alcoholism.

He tries to think things out for himself. He says, "There's no disputing the fact that my drinking has created a great deal of unhappiness in the family. It has made a shambles of our lives."

Pride replies, "Yes, that is true, but you can change these things for the better. All you have to do is stop drinking. Your wife will be happy; you can pay your bills. Life will be beautiful. Don't admit failure; trust in me."

One Drink Not Enough

The alcoholic complains, "But I can't seem to stop drinking. I've tried it many times, and sooner or later I can't resist taking a drink, and you know as well as I do that I can't stop with one drink."

Pride sighs, "Sometimes I wonder about you, friend. Are you going to admit to *me* that you haven't enough will power to stop drinking. What if you have failed in the past? To succeed you must keep trying. And as

for that idea of yours that you can't stop with one or two drinks, even if your will power should slip for a moment, forget it. Your enemies have planted that idea in your head so many times you're beginning to believe it. Snap out of it, friend. Next time you take a drink, if there is a next time, I'll show you—and them—that you can handle your liquor as well as anybody. You're not weak; you're just too open to suggestion."

Degrading Thought

The alcoholic looks hopeful but worried. "I guess I see what you mean when you say my enemies want me to admit I can't handle my liquor. It's a degrading thought they have been trying to plant, but you'll have to leave my wife out of that category. I know that she's sincere when she says she will never be happy until we can live a normal, sober life together. She's suffered . . . "

Pride sneers, "*She's* suffered? What about *you?* Are you forgetting all the things she did that caused you to drink excessively in the first place? *She* wants! It's always '*she* wants.' She wants to control your life. That's what she wants. She wants to manage the budget, decide the color of your necktie, pick your friends for you, snap her little finger and see you jump. It's always been that way. If it hadn't been for me you would never have been able to fight her ridiculous wants. You'd be a spineless puppet hanging from her dainty apron strings."

The alcoholic looks ruffled, "How do you fit into that picture? It was whisky, not Pride, that let me show her I was the man of the house. It was whisky that made me overdo it, too, from time to time. I never should have slapped her around like that."

Pride grins smugly, "Whisky, my friend, was merely the catalyst, the agent that released me from the bonds of your timidity, so that I could stand up for your rights. If I left it entirely up to you, you would never generate enough courage to fight at those who are trying to destroy you. I won't let them destroy you. My two most trusted lieutenants are with you every minute to prod you out of your dangerous lethargy, to keep you alert. You should know them well. They've played a big part in your life. Their names are Defiance and Resentment. Ah, I can see by that look in your eye that you remember them now. Well, give credit where credit's due, I always say."

The alcoholic says nothing for a moment. Then he asks, "What must I do?"

Pride Wins

Pride breathes a sigh of relief, "Do? Why, there's just one thing *to* do. Do what you said you would do. Stop drinking. Take the treatment if that's what they want you to do. Sometimes its best to sort of 'go along' —make them believe you're sincere. But just remember one thing while you're making these noble gestures: I'm the best friend you ever had, and if you don't want to lose me forever, don't try to double-cross me by playing around with Humility."

And with a satisfied chuckle Pride lies down and rests in the sumptuous quarters provided for him in the inner recesses of the alcoholic's mind, content in the knowledge that he has won another victory in the battle against Reason.

There will be another day, another battle, and sooner or later the alcoholic will learn from the experience. The new teacher will be Humility. The study course will be Living Realistically, and the new knowledge will enable him to live soberly in peace and contentment with himself and his fellowman.

Happiness is not a station we arrive at; it's a way of traveling.
—From *A. A. Grapevine*

Your Extra Twenty Years

(Continued from page 6)

cessfully by physicians who are specially trained for this work.

Neither is it the fault of the medical profession, which is doing everything possible to help old people (as well as young people) understand that many of their aches and pains and feelings of fatigue and listlessness are symptoms of emotional illness, not physical illness, and should be accepted and treated as such.

New Field

It's nobody's fault really that some refuse to accept the modern concepts of mental health and emotional illness. It's simply that this is a relatively new field of scientific human endeavor. While it has made remarkable progress in the last 50 years it has not had time to progress as far as the physical sciences have advanced, and as a consequence there is still considerable public resistance to this science that deals with intangible, *personal* things like attitudes and feelings. There always has been and probably always will be public resistance to new concepts, new ideas, and new approaches to public health problems. Many of us can remember the shame with which the public once viewed tuberculosis, epilepsy, and venereal disease. Medical science and public education eventually removed the stigma.

By the time the shame and stigma have been removed from all mental illnesses many will have spent all of their extra years in emotional misery. This is regrettable, but there is a cheerful note so far as you and I and our children are concerned. We are in a position to insure our extra years against emotional illness by learning all we can about mental health, by striving for emotionally healthy attitudes, and by encouraging appropriations for research, education, and facilities in this vital field.

Mental Health Statistics

In this connection you may be interested in a few statistics about mental illness in the United States today: Six to seven per cent of the total population is suffering from a mental or personality disorder. Ninety per cent of these can be treated without hospitalization. Psychiatrists, working privately or as members of professional teams including psychologists, psychiatric social workers, and others in Mental Hygiene Clinics, are helping thousands of adults and children to overcome their neuroses and to adjust happily to life situations. Who can deny that many of these patients are thereby prevented from developing more serious forms of mental illness?

Nine Clinics In N. C.

There are today in the United States 1,154 Mental Hygiene Clinics. Only nine of these are in North Carolina. Three are at the medical schools and six are community clinics, supported partially by the State Board of Health. This meets less than one-fourth of the existing need in North Carolina.

It seems to us that if we want the best possible chances for living our extra twenty years in emotional health as well as physical health and then passing on to our children this happy heritage we ought to give some serious thought to these statistics. And then do something about it!

ATTEND SUMMER STUDIES ON

FACTS ABOUT ALCOHOL

FOR TEACHERS AND PROSPECTIVE TEACHERS

Offering Three Quarter Hours College Credit

- **EAST CAROLINA COLLEGE**
  Greenville, N. C.
  June 7-17, 1955

- **FAYETTEVILLE STATE TEACHERS COLLEGE**
  Fayetteville, N. C.
  June 27-July 8, 1955

- **APPALACHIAN STATE TEACHERS COLLEGE**
  Boone, N. C.
  July 5-15, 1955

- **A. & T. COLLEGE**
  Greensboro, N. C.
  June 20-July 1, 1955

- **NORTH CAROLINA COLLEGE**
  Durham, N. C.
  June 13-24, 1955

The State law requires that instruction about alcohol be given in the public schools. The North Carolina Alcoholic Rehabilitation Program, recognized as a leader in the field of alcoholism treatment and education, co-sponsors this course with East Carolina College, North Carolina College, Fayetteville State Teachers College, A & T College, and Appalachian State Teachers College. For details and tuition costs, write the Registrar of the nearest college.

LECTURERS

S. K. PROCTOR, Executive Director, North Carolina Alcoholic Rehabilitation Program.
NORBERT L. KELLY, Ph. D., Education Director, NCARP.
JOHN EWING, M.D., Psychiatrist, N. C. Memorial Hospital, Chapel Hill.
FRED ELLIS, M.D., The University of North Carolina, Chapel Hill.
LORANT FORIZS, M.D., Clinical Director, NCARP Treatment Center, Butner.

SOME OF THE SUBJECTS COVERED

The Nature and Extent of Alcohol Problems
An Educational Philosophy for Instruction About Alcohol
The Dynamics of Personality Development
Organization of Materials, Procedures, and Techniques for Instruction About Alcohol
Some Aspects in the Causation and Treatment of Alcoholism
Educational Procedures and Techniques in the North Carolina Schools

EYE OPENERS

The *Digest of Neurology and Psychiatry* is a handy little publication of the Institute of Living in Hartford Connecticutt, presenting capsule reviews of selected literature. Recently reviewed therein was an article by Dr. G. Colket Caner, first published in the New England Medical Journal, dealing with the use of suggestion in psychotherapy. "The goal of psychotherapy," the author believes, "is the modification or change of attitudes and reaction patterns. It is generally conceded that suggestion can powerfully influence thinking, either for good or ill. Before the emergence of psychoanalysis, practically all psychotherapists intentionally made use of suggestion, often with excellent results, and there is no doubt that suggestion plays an important part in all psychotherapy, whether or not it is used intentionally.

An item in a recent Time Magazine reports that two scientists named Dougherty and Eyring have produced a radical answer to the problem of why body tissues suffer severe damage because of fatigue or worry. "Doctors have long recognized a medical fact," says Time, "that people make themselves ill through strain or worry." But they didn't know exactly what happened to individual body cells under stress. Scientists Dougherty and Eyring's answer: "stress sets off a destructive chain reaction among the body cells, with a substance called *histamine* acting as the destructive agent." Present anti-histamine drugs have only a temporary effect against the cell-saboteur, histamine. Dougherty and Eyring hope to develop a drug which will stop the destructive process and bring stress-burdened modern man longer life.

The alcoholic who has achieved sobriety is apt to "feel like a new man." Actually, reports *Today's Health*, scientists have found that we are all new men—or practically so—each year that we live. "New studies find that about 98 per cent of all the atoms in your body right now will be replaced within the year by atoms taken from the air you breathe or your food and drink. This is shown in experiments made with radioactive atoms which can be traced wherever they go. Dr. Paul C. Abersold of the Atomic Energy Commission writes in the annual report of the Smithsonian Institute, Washington, D. C., " 'Our body processes are continually breaking down and building up organic molecules. The breaking-down process . . . releases the energy which is necessary for the proper functioning of our bodies.' "

One of our most serious problems is that of the drinking driver. All sorts of devices have been brought out to determine intoxication—and thereby establish the drinking driver's guilt or innocence. There is the old-fashioned blood test, the drunkometer, and perhaps the most famous, the alcometer, devised by Dr. Greenberg of Yale University. Medical men and law enforcement officers report that none of these devices has entirely solved all the problems involved. Japanese scientists have come up with still another method of determining intoxication, reports the current issue of *Alert*. They have reportedly developed a method of testing drunkenness by measuring brain waves.

A list of available literature

FROM THE N. C. ALCOHOLIC REHABILITATION PROGRAM

complete and free for the asking

The following are available in reasonable quantity:

(1) **A CLOSER LOOK AT THE ALCOHOLIC—FORIZS**
Explains some of the personality factors which lie at the roots of alcohol addiction.

(2) **THREE PHASES OF REHABILITATION—FORIZS**
Designed to show that sobering up is only the first stage of rehabilitation for the alcoholic, and outlines the further steps to recovery.

(3) **A MINISTER LOOKS AT ALCOHOLISM—SHEPHERD**
Discusses the contribution that organized religion can make toward the treatment and prevention of alcoholism.

(4) **THE CHURCH AND ALCOHOL PROBLEMS—BINKLEY**
An explanation of the changes being brought about in the attitudes of the churches as a result of recent advances in research on alcohol problems.

(5) **WE DIE TO LIVE—AA**
An A.A. member sets forth four paradoxes which give a clue to the phenomenal success of Alcoholics Anonymous.

(6) **TESTS FOR ALCOHOLISM**
Designed to give some basis for determining whether or not an individual is developing, or already has the illness.

(7) **EMOTIONAL MATURITY—KELLY**
A social scientist explains twelve important learning experiences which help guide us to emotional health.

(9) **HOW TO HELP AN ALCOHOLIC—CHAMPION**
Good advice for those who want to help someone recover from alcoholism—a family member or a friend—but don't understand how to go about it.

(10) **12 EXCUSES FOR GETTING DRUNK—CHAMPION**
Excuses which alcoholics frequently use to deceive themselves about their developing drinking problem. Illustrated.

(11) **PREVENTION OF ALCOHOLISM BEGINS IN THE HOME—KELLY**
Outlines how parents can immunize their children against emotional illness through sound mental health practices in the home.

(14) **THE NEW CORNERSTONES—CHAMPION**
A basic manual on alcohol and alcoholism, written in simple, straightforward language. For both layman and professional worker.

(15) **FACTS ABOUT ALCOHOL AND ALCOHOLISM—CHAMPION**
In cartoon, question and answer style, this booklet attempts to correct some misconceptions about alcohol and alcoholism.

(16) **THE NCARP TREATMENT CENTER BROCHURE—ADAMS**
Through word descriptions and photographs, this booklet explains in detail what the alcoholic can expect from his 28-day stay at the Treatment Center.

(17) **13 STEPS TO ALCOHOLISM**
Fifteen page pamphlet explaining some of the early and late warning signals of alcoholism.

(18) **AA—A UNIQUELY AMERICAN PHENOMENON**
Describes the growth and development, and the program for sobriety of that unique fellowship—Alcoholics Anonymous.

(19) **HOW TO KNOW AN ALCOHOLIC**
Answers the question—What is an alcoholic? Who is an alcoholic? Who is not an alcoholic? Is he or she really an alcoholic? How to help an alcoholic. What you can do about an alcoholic.

(20) **ALCOHOL AND THE ADOLESCENT—BLOCK**
Gives parents a factual basis for answering their teen-agers' questions about drinking.

(21) **ALCOHOL, CATS, AND PEOPLE—JELLINEK**
Explores the psychological effects of alcohol as indicated by the behavior of alcohol-fed cats in the laboratory.

The following are available in single copies to professional people only:

(22) **THE OCCURRENCE OF CERTAIN PSYCHOSOMATIC SYMPTOMS DURING DIFFERENT PHASES OF THE ALCOHOLIC'S LIFE—CATHELL**
A scientific treatise, reprinted from the N. C. Medical Journal.

(23) **ALCOHOLISM: A SICKNESS THAT CAN BE BEATEN**
A 28-page Public Affairs Pamphlet, covering the illness of alcoholism—its causes, treatment, and prevention.

(24) **PROBLEM IN BUSINESS AND INDUSTRY**
Pamphlet describing the tremendous costs to business and industry caused by problem drinking among employees, and suggesting ways of attacking the problem.

(26) **ALCOHOLISM, A PERSONAL AND COMMUNITY PROBLEM**
A compilation of lectures given at the 1952 Summer Studies on Facts About Alcohol at the University of North Carolina. Brings into focus many of the medical, social, and educational approaches.

(27) **FACTS ABOUT ALCOHOL—McCARTHY**
A 48-page illustrated booklet for use primarily by teachers in planning their units on alcohol study.

(28) **ALCOHOLISM AND SOCIAL EXPERIENCE—KELLY**
A discussion of research into the social histories of 250 anonymous former patients of the NCARP Treatment Center.

(29) **INSTITUTIONAL CARE FOR N. C. PROBLEM DRINKERS**
An investigation of general hospitals, mental institutions, and specialized treatment centers providing treatment for the alcoholic in the state.

N. C. ALCOHOLIC REHABILITATION PROGRAM
15 W. JONES ST., RALEIGH, N. C.

Please send me the publications I have circled below. I have indicated beside each item the quantity desired.

1.___ 2.___ 3.___ 4.___ 5.___ 6.___ 7.___ 9.___ 10.___ 11.___
14.___ 15.___ 16.___ 17.___ 18.___ 19___ 20.___ 21.___ 22.___
23.___ 24.___ 26.___ 27.___ 28.___ 29.___

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Street and Address _____

City and State _____

WHAT THEY'RE SAYING ABOUT

THE NEW CORNERSTONES and the NEW BROCHURE

The New Cornerstones is an excellent, practical, and very helpful publication. It is just the type of literature I've long wanted. Thanks again for its publication.

Rev. Randolph L. Gregory
First Baptist Church
Wilmington, N. C.

Please send me twelve copies of the manual entitled, The New Cornerstones. I am sure that it will be of great help to me in my work with alcoholics and their families.

Laura McMillan
Public Health Educator
Charlotte, N. C.

Your ARP family manual, The New Cornerstones, is excellent. Many of us are deeply grateful for these services you are rendering.

Rev. J. K. Parker, Jr.
First Presbyterian Church
Boone, N. C.

Would you please send us fifty each of The Treatment Center Brochure and The New Cornerstones. It is our plan to supply each of our nurses with a copy of these publications; and in addition we will reserve a limited supply for other interested persons.

Laura S. Breese
Health Educator
Gaston County Dept.
of Public Health
Gastonia, N. C.

I have read your recent publication, The New Cornerstones, and think it excellent. Please accept our congratulations on it. We think we can use about fifty copies if you can spare that many for us.

Beatrice H. Coe
Psychiatric Social Worker
Graylyn Alcoholic Clinic
Winston-Salem, N. C.

I appreciate very much the work that you are doing and would like very much to obtain a number of brochures on the Treatment Center and the pocket-sized manual called The New Cornerstones. I have already given away the copy I received a few days ago and feel that these may benefit a number of alcoholics and persuade them that they can benefit by this treatment.

Leon T. Kennedy, M.D.
Charlotte, N. C.

We have examined with interest your new booklet entitled, The New Cornerstones, and believe it should be most helpful.

Charles R. Brockman
Assistant Director
Charlotte Public Library
Charlotte, N. C.

It seems to me that it is one of the best publications I have yet received from your office.

Rev. Charles E. Shannon
St. Paul's Methodist Church
Asheville, N. C.

I am maintaining a shelf of literature on the subject (alcoholism) in my own Myers Park Methodist Church, where I teach an adult class of 165 members and assist in the work of the Woman's Society. If you can spare me fifty copies of each of the new publications, I can assure you that I shall be able to put them to good use.

Mrs. Louis K. Rogers
c/o Myers Park Methodist Church
Charlotte, N. C.

I deeply appreciate your kindness in sending to me recently a brochure and a manual regarding alcoholism and the work of the N. C. Alcoholic Rehabilitation Program. I will appreciate twelve copies each of the Treatment Center Brochure and The New Cornerstones.

Rev. John Ivan Kizer
First Baptist Church
Hazlewood, N. C.

Please send a supply of publications—The New Cornerstones and the NCARP Treatment Center Brochure. I read these publications. They are excellent. It would be an excellent phase of public education if the general public read them.

H. A. Eldridge, M.D.
Dunn, N. C.

I would appreciate several more copies of the Cornerstones and also the Treatment Center Brochure. Several of the articles in INVENTORY have proved helpful to several of my patients and I appreciate receiving them.

Norman H. Garrett, M.D.
Greensboro, N. C.

I received the two publications you sent me this date. I wish to thank you for them and commend you for a fine job. I would definitely like to have some copies to distribute.

Rev. Robert G. Balnicky
Troy Presbyterian Church
Troy, North Carolina

I thank you most heartily for the brochure, The NCARP Treatment Center, and the manual, The New Cornerstones. We pastors will find much help in these publications.

Rev. Earl K. Bodie
Evangelical Lutheran Parish
Gibsonville, N. C.

Thank you so much for sending me copies of the New Cornerstones that I had requested. The manuals were much in demand, and I have only one left. I believe I am going to need at least twenty-five more copies.

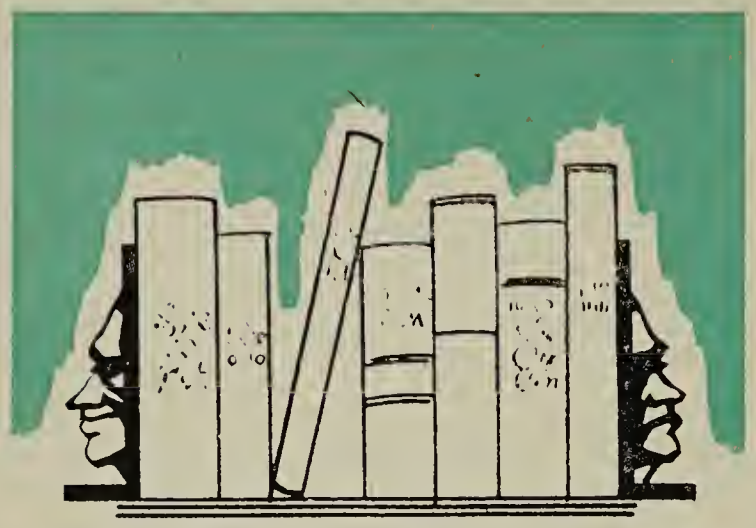
Effie Maiden
Public Health Educator
Charlotte, N. C.

I have found a great deal of interest in the two publications recently sent me from your office. They should be of great help in cases with which I have to deal from time to time.

Rev. C. Arthur Francis
First Baptist Church
Monroe, N. C.

Thank you very much for the copies of the two booklets, which you recently sent me. I would appreciate it very much if you would send me ten more copies of each of these booklets as I, from time to time, can use them in my practice.

Norman Boyer, M.D.
Medical Director
Ecusta Paper Corporation
Pisgah Forest, N. C.



Books of Interest

MENTAL HEALTH IN THE HOME

$3.50

By Laurence S. McLeod, Ph.D.
New York: Bookman Associates

ALCOHOLISM is increasingly being recognized as a family illness. Many if not most cases of the sickness appear to have their origin in early parent-child relationships. Moreover, marital problems in adult life seemingly provide the precipitating causes for the actual onset of excessive drinking in numerous cases. Any book, therefore, devoted to wholesome family living and enlightened mental hygiene practice in the home should be of unusual interest to those recovering from alcoholism and those concerned with its prevention. Such a book is Dr. McLeod's MENTAL HEALTH IN THE HOME.

The volume begins by showing how important the early years of life are for laying a foundation for enduring mental health. The vital importance of the child's acquiring self-reliance, a sense of security and adequacy, and of developing increasing independency of action is emphasized. These are behavior traits parents must recognize as imperatives in the development of their children and must encourage their children to develop. These are also behavior traits many, many alcoholics, as adults, do not possess, for as children they were never permitted to develop them.

Dr. McLeod believes that religion is a very practical aspect of living and can be greatly rewarding for emotional balance. The religious values of service, humility, tolerance, and positive conduct can be of immeasurable value to emotional equilibrium, the author maintains.

In the important life area of marital relations, the necessity for democracy and cooperation between husband and wife is stressed. In the opinion of the author, this cooperation includes not only a joint responsibility for the rearing of the children—too often this has become the woman's sphere—but it also involves a mutual responsibility in housekeeping.

Additionally, the author believes that husband and wife should be comrades as well as lovers. Intimate love is indispensable to a satisfactory marriage, of course, but nights-out together, carrying on common recreational interests, shared hobbies, friends, joint community interests are also of profound value in maintaining both emotional health and marital zest.

Dissatisfaction With Work

An important precipitating element in some cases of alcoholism is dissatisfaction with one's occupation. Dr. McLeod discusses the vital importance of the correct selection of a job and shows the significance for personality equilibrium of wholesome work attitudes and good work habits.

All of us, not only the recovering alcoholic, need to take a periodic inventory of ourselves. This book, I believe, provides the basis on which such an inventory may be based, for it covers many phases of life: home and family, religion, work, recreation. Certainly all these areas are directly concerned with the state of our mental health at any given time.

—Norbert L. Kelly, Ph.D.

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
415 Halifax St.
RALEIGH, N. C.
Phone: 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: 3-8343
Monday through Friday

Mental Hygiene Clinic
210 N. Greene St.
GREENSBORO, N. C
Phone: 3-9426
Also at HIGH POINT
Phone: 8929
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
Chapel Hill, N. C.
Phone 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: 3-5441 & 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: 3-2471, Ext. 29
Monday through Friday

Graylyn Hospital
WINSTON-SALEM, N. C.
Phone: 3-7391
FRIDAY ONLY. This is purely a Clinic for alcoholics and their families. Out-patient mental hygiene clinic is located at Baptist Hospital, Winston-Salem.

Toward helping patients to re-establish satisfactory social relations all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Kits—kits containing books and pamphlets on alcoholism. Available to libraries from N. C. Library Commission, State Library, Raleigh.

Book Loan Service—kit of reference works on alcohol and alcoholism, for high schools. Order from Education Director, 15 W. Jones St., Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
15 W. Jones St.
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.